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MEDICAL MALPRACTICE AND TORT REFORM: ISSUES OF INSURANCE COSTS, COVERAGE, CAPS, AND COMPENSATION

A Report to the 54th Legislature from the

JOINT INTERIM SUBCOMMITTEE ON INSURANCE ISSUES

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A Report to the 54th Legislature
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JOINT INTERIM SUBCOMMITTEE ON INSURANCE ISSUES

Prepared by
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SENATE JOINT RESOLUTION 31

A JOINT RESOLUTION OF THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA REQUESTING AN INTERIM STUDY OF INSURANCE-RELATED PROBLEMS, INCLUDING THE HIGH COST OF MEDICAL MALPRACTICE INSURANCE, PROPOSALS FOR GENERAL TORT REFORM, AND GENERAL QUESTIONS INVOLVING PUBLIC AND PRIVATE LIABILITY ISSUES; AND REQUIRING A REPORT OF THE FINDINGS OF THE STUDY TO THE 54TH LEGISLATURE.

WHEREAS, several bills have been introduced in the 53rd Legislative Session requesting immunity from liability for various groups, including private enterprises relating to various occupations as well as governmental agencies; and

WHEREAS, several bills relating to tort reform have been introduced in the 53rd Legislative Session; and

WHEREAS, it is reported that, in Montana, many rural and urban areas are having difficulty in obtaining and retaining health providers, particularly those practicing in the area of obstetrics and gynecology; and

WHEREAS, there is evidence that doctors and other health care providers, businesses, and others may have difficulty obtaining insurance coverage and liability protection at reasonable rates;and

WHEREAS, as the cost of insurance continues to grow, it continues to consume a larger percentage of income and is approaching the point of placing liability protection out of the reach of businesses and individuals in Montana; and

WHEREAS, the high cost of insurance may seriously threaten the provision of certain goods and services to the state's citizens;and

WHEREAS, proposed solutions to the complex problems of insurance coverage and protection and public and private tort liability are not easily identified and adequate and effective solutions may not be obtainable within the pressures of a legislative session;and

WHEREAS, a thoughtful and reasoned study of the myriad aspects of insurance costs and availability, tort reform proposals, and public and private liability, in addition to other studies that are specific to other subject matters that are being proposed in this 53rd Legislative Session, would aid in the solution of these complex issues.

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA:

(1) That a special joint interim committee, to which the full subpoena power of the Legislature and the Legislative Council is extended, be assigned to study and to prepare legislation, if recommended, to address:

(a) insurance problems, including the cost of medical malpractice insurance and how to make insurance coverage and protection available to Montana citizens at a reasonable cost;

(b) the effectiveness of various tort reform proposals; and

(c) general questions involving public and private liability, including but not limited to the issues of public and private immunity, punitive damages, structured settlements, joint and several liability, caps on damage awards, attorney fees, reinsurance, and penalties for bringing frivolous lawsuits.

(2) That, when appropriate, the study be coordinated with the study of tort reform and defensive medicine provided for in Senate Bill No. 285.

SUMMARY OF RECOMMENDATIONS

1. Amend the statute of limitations for medical malpractice actions to allow the application of the statute to other actions arising out of medical malpractice claims.

2. Amend the Montana Medical Legal Panel Act to require the panel to articulate its reasons for each decision and to require mandatory, nonbinding mediation for an affirmative panel decision.

CHAPTER ONE
OVERVIEW

INTRODUCTION

Senate Joint Resolution No. 31 (SJR 31) requested that an interim study be conducted on: (1) problems relating to the cost and availability of liability insurance, including medical malpractice insurance; (2) issues involving public and private liability; and (3) general tort reform.

The study was requested as a result of the Legislature's inability to address various liability insurance and tort reform issues that arose during the 1993 session. During the session, a number of bills were introduced relating to public and private liability, including a bill to eliminate joint and several liability and several bills to provide immunity from liability for various groups. Several bills relating to tort reform were also introduced. In addition, testimony was offered during the session stating that doctors, other health care providers, businesses, and certain individuals were having difficulty obtaining liability insurance coverage at reasonable rates. The Legislature found that these issues and proposed solutions could not be easily considered "within the pressures of a legislative session". Thus, SJR 31 was introduced in the belief that "a thoughtful and reasoned study" of the issues and proposals brought before the 1993 Legislature would aid in resolving these issues.

HOUSE BILL NO. 346

House Bill No. 346 (HB 346) was the major piece of legislation on medical malpractice in the 1993 session and died in the conference committee stage of the legislative process. The contentious nature of the bill is illustrated in the numerous changes made to it during the legislative process.

As introduced, the bill contained provisions on:

(1) caps on noneconomic damages of $250,000 for a single incident, whether for one or more claimants in the same or separate proceedings; whether based on the same act or a series of acts that allegedly caused the injury, injuries, death, or deaths; and whether the act or series of acts were by one or more health care providers;

(2) a limit on the contingency fees of plaintiffs' attorneys in medical malpractice cases;

(3) mandatory periodic payments for awards of $100,000 or more;

(4) limits on liability of health care providers for specific emergency situations; and

(5) further limit on the statute of limitations within which a medical malpractice claim may be filed.

The House Judiciary Committee amended the bill in several areas, including raising the cap for noneconomic damages to $500,000 and adding nurses to the definition of health care providers. The sections limiting liability for health care providers and amending the statute of limitations were deleted. The bill passed the House as amended.

In the Senate Judiciary Committee, the bill was substantially amended to limit the cap on damages to $500,000 per claimant and to revise the definitions of "malpractice claim" and "noneconomic loss", the section on limiting attorney contingency fees was deleted, and the section on periodic payments was amended. The bill was concurred in as amended by the Senate, but the amendments were not accepted by the House. The bill was placed in a conference committee but was never reported out of committee and died in the process.

ISSUE SELECTION

The Joint Interim Subcommittee on Insurance Issues (Subcommittee) was created to conduct the study requested in SJR 31. The Subcommittee held five meetings between September 1993 and August 1994. In the first two

meetings, the Subcommittee explored the various areas of concern listed in SJR 31 in order to determine the areas most in need of study. Interested persons requested that the various issues in HB 346 be studied separately by the Subcommittee.

The Subcommittee received information on the insurance and tort reform issues that were studied by a 1986 interim subcommittee and legislation passed in the 1987 session[1], along with information on legislation passed in the 1993 session[2]. Significant tort reform measures had been passed since the 1986 study, and many interested persons indicated that those areas should be left alone.

At the first meeting, the Subcommittee members requested an educational session on the insurance and liability issues raised during the 1993 session. At its second meeting, the Subcommittee reviewed 12 staff papers on the following issues:

(1) frivolous lawsuits;

(2) comparative negligence;

(3) collateral source;

(4) joint and several liability;

(5) medical malpractice;

(6) immunity and liability;

(7) caps on damage awards;

(8) punitive or exemplary damages;

(9) structured settlements/periodic payments;

(10) attorney fees/contingency fees; and

(11) reinsurance.[3]

After the presentations and testimony on the 12 issue papers, the Subcommittee decided to concentrate on the issue of medical malpractice.

Focusing on medical malpractice subsumed some of the other tort reform concepts of attorney contingency fees, caps on damages, and periodic payments.

MEDICAL MALPRACTICE

The third meeting was devoted to medical malpractice information available in and about Montana. The Subcommittee staff sought information to assist the Subcommittee in defining the medical malpractice problem. The staff collected data and reported on the number of medical malpractice claims in Montana, the dollar amounts of settlements and awards, and premium rates. The staff encountered difficulty in obtaining information and being able to compare or verify information.

Despite these difficulties, the information that was collected allowed the Subcommittee to ascertain trends in the state. The information indicated that there was a competitive, albeit limited, professional liability insurance environment in which physicians could purchase insurance. The average and median dollar amounts of settlements were lower than the suggested caps, and there were few million-dollar or multimillion-dollar cases. Very few claims resulted in lawsuits; only a small number of claims eventually received a verdict; and the majority of verdicts were in favor of the defendant physicians.

REGULATORY PERSPECTIVE AND RATEMAKING

At the fourth meeting, the Subcommittee received information from the Office of the Commissioner of Insurance (Commissioner) on medical malpractice insurance from a regulatory perspective. The Commissioner reported that his office receives few complaints in this area; that competition is good, as illustrated by the fact that an additional insurance company recently became licensed and another company was expressing interest; and that no companies had left the state in recent times.

At a previous meeting, the Subcommittee had been advised to learn more about ratemaking for medical malpractice insurance. Randy Nordquist, actuary for the Commissioner's Office, gave the Subcommittee a detailed report on the complexity of ratemaking[4]. Some of the variables that go into ratemaking include investment income, expenses and profits, loss development, adjustment of premiums to current rate levels, allocated loss adjustment expenses, deductibles, inflation, judicial climate, and credibility of data.

Mr. Nordquist stated that legislative decisions play a part in the process of making rates, but a company will protect its interests and not react too quickly to legislative changes. Montana is a very small part of the national market, and the Commissioner's Office is dedicated to balancing the need for flexibility with the need to ensure availability. Even if premiums were lowered as a result of legislative changes, there was no assurance that the savings would be passed on to consumers.

OTHER STATES

The Subcommittee staff researched statutory provisions in the surrounding states of North Dakota, South Dakota, Wyoming, and Idaho in the areas of collateral source rules, periodic payments, caps on damages, prescreening review panels, and other statutory provisions specifically related to medical malpractice. The Subcommittee concluded that the data showed no significant pattern to indicate that any one single reform was responsible for lower premiums.

Professional liability insurance premium rates were also obtained for the same four states. Wyoming's rates were the highest, but the Wyoming Medical Society members receive a 20% discount, which is not reflected in the rates. South Dakota has the lowest rates, but a representative of the South Dakota Insurance Department explained that their rates are low because 90% of the coverage is provided by one company, St. Paul Fire and Marine (St. Paul). The significance of South Dakota's one-company status is clearly indicated with St.

Paul's involvement in an excessive-rate lawsuit in the late 1980s. In 1989, St. Paul reduced its premium rates by 25%, and they have not been raised since then. South Dakota also has a cap on damages that may affect the rates. The premium rates in Montana, Idaho, and North Dakota vary depending on the various class codes. It is inconclusive whether legislation in any of these states directly affected the premium rates.

Information was offered by interested persons from other states, such as California, Indiana, and New Jersey, but they conceded that those states' intensive litigation and judicial climate and their urban nature make comparison to Montana's circumstances debatable.

MONTANA HEALTH CARE AUTHORITY

The Subcommittee was aware that the Montana Health Care Authority (Authority) had been directed by Senate Bill No. 285 (Ch. 606, L. 1993) to conduct a study of tort reform measures in relation to defensive medicine. The Subcommittee's directive included many of the same tort reform measures, but not specifically in relation to defensive medicine. The Subcommittee was urged by interested persons to cooperate with the Authority in a study of tort reform. The Subcommittee agreed to study the medical malpractice issue in conjunction with the study by the Authority.

Due to the differing timelines of the Subcommittee and the Authority, reports were given periodically to each respective group on the other's progress. Because the Authority had other requirements to meet, it indicated that it would review the Subcommittee's conclusions. The Subcommittee's study and recommendations were eventually completed and forwarded to the Authority.

FINAL CONSIDERATION AND RECOMMENDATIONS

The final meeting of the Subcommittee was dedicated to reviewing proposals for legislation from interested parties.

The Montana Medical Association pursued legislation to institute a general cap on all noneconomic damages, contingency limits for attorney fees, and mandatory periodic payments for medical malpractice awards.

The Subcommittee staff presented legislation, prepared at the request of the Code Commissioner, clarifying language in two sections regarding medical malpractice statutes of limitation.

The Montana Trial Lawyers Association (MTLA) proposed legislation: (1) revising the Montana Medical Legal Panel Act (Title 27, chapter 6, MCA) to include requiring an explanation of decisions of the Montana Medical Legal Panel (Panel); mandatory, nonbinding mediation; written transcripts for hearings upon request; and summary disposition of Panel claims; (2) limiting fees charged for health care information; and (3) requiring physicians to carry professional liability insurance.

The staff also presented proposed legislation, based on an idea from the Commissioner's actuary, regarding mandatory reporting of medical malpractice experience to the Insurance Services Office.

The Subcommittee approved the legislation recommended by the Code Commissioner and the provisions recommended by the MTLA revising the Montana Medical Legal Panel Act to require an explanation of the Panel's decision and to require mandatory, nonbinding mediation. The Subcommittee concluded that there was not sufficient evidence provided to it to warrant the approval of the remainder of the requests for legislation. The evidence did not support the assertion that there was a medical malpractice crisis in Montana, nor did the evidence support the proposition that the proposals would result in health care costs savings to the consumer.

ENDNOTES

1. Connie F. Erickson, Revisiting the 1986 Joint Interim Subcommittee on Liability Issues, Montana Legislative Council, September 1993.

2. Susan Byorth Fox, Selected Insurance, Liability, and Immunity Legislation Considered by the 1993 Montana Legislature, Montana Legislative Council, September 1993.

3. Connie Erickson, Susan Byorth Fox, and David Niss, Issues Before the Joint Interim Subcommittee on Insurance Issues, Montana Legislative Council, December 1993.

4. Subcommittee on Insurance Issues, Minutes, June 24, 1994, Montana Legislative Council.

CHAPTER TWO
ISSUES BEFORE THE SUBCOMMITTEE

INTRODUCTION

House Joint Resolution No. 31 directed a joint interim subcommittee to address general questions involving public and private liability, including public and private immunity, punitive damages, structured settlements, joint and several liability, caps on damage awards, attorney contingency fees, reinsurance, and frivolous lawsuits. In addition, the Subcommittee was directed to address the issue of medical malpractice insurance.

ISSUES

Issue Number One: Frivolous Lawsuits

Black's Law Dictionary defines a frivolous action as a "groundless lawsuit with little prospect of success". The Rules of Professional Conduct for lawyers prohibit them from bringing or defending a proceeding unless the basis for doing so is not frivolous, meaning that there is a good faith argument for the proceeding. The Rules also require a lawyer to not represent a client or to withdraw from representation if the representation will result in a violation of the Rules of Professional Conduct.

Other than bad faith, there are other reasons for questionable lawsuits being filed. Lack of sufficient legal research, attempts to reach a "deep pocket", errors in judgment, and near expiration of statutes of limitation are all possible reasons. Whatever the reason, a lawsuit brought without a serious belief of liability should be avoided if the judicial system is working fairly and properly.

There are traditional common-law remedies against frivolous lawsuits: the remedy of malicious prosecution and an action for abuse of process. Both

remedies require proof of malice and a showing of improper purpose in the use of the legal process.

Rule 11 of the Montana Rules of Civil Procedure requires every pleading, motion, or other paper of a party represented by an attorney to be signed by at least one attorney of record. In signing the paper, the attorney is verifying that the lawsuit is grounded in fact and warranted by existing law or a good faith argument for the modification or reversal of an existing law. The paper also certifies that the lawsuit is not intended for any improper purpose, such as to harass or cause unnecessary delay or needless increase in the cost of litigation.

Statutory sanctions against frivolous lawsuits may also be imposed. However, those sanctions must pass constitutional muster. In order for a statute that modifies or restricts full legal redress to be constitutionally valid, the state must show that a rational relationship exists between the modification or restriction and a legitimate state interest.

There are two Montana statutes that address the issue of frivolous lawsuits: 25-10-711 and 37-61-421, MCA. Section 25-10-711, MCA, states that in any civil action brought by or against the state, a political subdivision, or an agency of either entity, the prevailing opposing party, whether plaintiff or defendant, is entitled to costs and reasonable attorney fees if the court finds that the claim or defense of the state, political subdivision, or agency was frivolous or pursued in bad faith.

Section 37-61-421, MCA, states that an attorney or party to any court proceeding who, in the opinion of the court, multiplies proceedings unreasonably or without real grounds may be required to personally pay the excess costs, expenses, and attorney fees reasonably incurred because of that conduct.

Issue Number Two: Comparative Negligence

Comparative negligence is a system of allocating damages between two or more persons in a tort action. Under comparative negligence, the damages collectible in relation to another person are diminished in proportion to one's degree of negligence. However, in most instances, if the plaintiff's negligence is greater than the defendant's, the plaintiff cannot collect damages.

According to Montana law, in cases resulting in injury or death, if the plaintiff's contributory negligence was not greater than the negligence of the defendant against whom recovery is sought, the plaintiff may recover damages. However, the damages allowed are diminished in proportion to the amount of negligence attributable to the plaintiff (27-1-702, MCA).

Issue Number Three: Collateral Source

Collateral source refers to compensation for injuries to a plaintiff from a source wholly independent of a defendant in a tort action. The collateral source rule is a traditional tort rule that prohibits a defendant from presenting evidence to a jury of the plaintiff's potential compensation from other sources for all or some of the economic losses that the plaintiff has alleged as damages. The purpose of the rule is to prevent payments from a collateral source from being deducted from the damages that the plaintiff would otherwise collect from the defendant.

Montana has a modified collateral source rule. In an action resulting from bodily injury or death, when the award against all defendants is in excess of $50,000, exclusive of court costs and attorney fees, the award must be reduced by any amount received from a collateral source that does not have a subrogation right. If the collateral source is an insurance policy payment, the premiums already paid by the plaintiff and the premiums to be paid by the plaintiff to keep the policy in force must be deducted from the policy payment before the reduction is made. The damage award is determined by the jury

without consideration of any collateral source. The reduction is made by the judge at a separate hearing (27-1-308, MCA).

Issue Number Four: Joint and Several Liability

Joint and several liability permits a plaintiff to collect the full amount of damages from any single defendant or combination of defendants in cases in which multiple defendants are found to have contributed to the injury or death, regardless of the relative fault of each defendant. This allows the plaintiff to seek full recovery from the defendant who is most able to satisfy the judgment.

Montana law recognizes the concept of joint and several liability but provides an exception. A party whose negligence is 50% or less of the combined negligence of all persons, including the injured person, is responsible only for the amount of negligence attributable to that party. In other words, the party is severally liable only. An exception to the 50% threshold applies to a party who acts in concert with another party or who acts as the agent of another party in contributing to the damages.

Issue Number Five: Medical Malpractice

Medical malpractice is negligent care by a health care provider that causes injury to a patient or the patient's death. A bad treatment result, no matter how severe, is not grounds for a malpractice action unless the provider was at fault. Medical malpractice claims are brought by injured parties who believe that they are the victims of negligence. In order to recover damages, a plaintiff must establish the following elements:

(1) the existence of the health care provider's duty to the plaintiff;

(2) a violation of the applicable standard of care;

(3) a compensable injury; and

(4) a causal relationship between the violation and the injury.

The Montana Medical Legal Panel Act (Title 27, chapter 6, MCA) was enacted in 1977 to prevent the filing of a medical malpractice suit if a valid malpractice claim does not exist and to ensure a fair and equitable disposition of a valid malpractice claim. The Montana Medical Legal Panel must review all malpractice claims or potential claims against a physician, dentist, or health care facility before an action can be tried in court. In 1989, the Legislature passed similar legislation for chiropractic physicians called the Montana Chiropractic Legal Panel Act (Title 27, chapter 12, MCA).

Issue Number Six: Immunity and Liability

In the context of the Subcommittee's area of interest, public immunity refers to governmental immunity from tort actions. Federal, state, and local governments are free from liability for torts committed, except in cases in which they have consented by statute to be sued. Private immunity refers to persons or entities who are free from liability for torts committed or whose liability is defined or restricted by law. A tort is a civil violation, other than a breach of contract, of a duty imposed by general law for which the court will provide remedy in the form of an action for damages.

Liability is governed under Title 27, chapter 1, part 7, MCA.

> Except as otherwise provided by law, everyone is responsible not only for the results of his willful acts but also for an injury occasioned to another by his want of ordinary care or skill in the management of his property or person except so far as the latter has willfully or by want of ordinary care brought the injury upon himself (27-1-701, MCA).

The exception allows for statutory criteria governing the extent of liability or, conversely, the amount of immunity from liability for various actions, such as furnishing alcoholic beverages, providing emergency care at the scene of an accident, donating food for free distribution, or designing emergency communication systems or firearms, or for certain persons, such as ditch company employees, nonprofit corporation officials, or health care providers who provide emergency obstetrical care to patients of direct-entry midwives.

Governmental entities are immune from suit for legislative acts and omissions(2-9-111, MCA) and for judicial acts and omissions (2-9-112, MCA). Quasi-judicial immunity applies to an agency that is designated by law as a quasi-judicial board and affords the members of that board immunity in their official investigation, hearing, and decisionmaking capacities (2-15-124, MCA).

The Montana Constitution, in Article II, section 18, states:

> The state, counties, cities, towns, and all other local governmental entities shall have no immunity from suit for injury to a person or property, except as may be specifically provided by law by a 2/3 vote of each house of the legislature.

Liability exposure of governmental entities (Title 2, chapter 9, parts 1 and 3, MCA) covers the immunities allowed the three branches of government and their employees--basically immunity from suit for acts or omissions arising out of the lawful discharge of official duties.

State and governmental entities are immune from exemplary and punitive damages (2-9-105, MCA); and there is a limitation on liability for damages in tort (2-9-108, MCA).

Issue Number Seven: Caps on Damage Awards

Damage awards refer to a sum of money awarded to a person injured by the tort of another. Damages may be compensatory for actual damages (economic or noneconomic) or punitive as punishment for outrageous conduct and to deter future transgressions. A cap on damage awards refers to a limitation by statute on the amount of damages that can be awarded. Limits are usually placed on governmental immunity, medical malpractice, noneconomic damages, punitive damages, and periodic payments.

Montana does not have many "caps" on damage awards. However, There are some statutes that limit or exclude damages in particular instances.[1]

Issue Number Eight: Punitive or Exemplary Damages

Punitive damages are imposed primarily to "punish" the persons who have acted intentionally or recklessly to injure the plaintiff or others. They are also referred to as "exemplary damages" because the imposition of these damages is intended to make an example to others and to act, presumably, as a deterrent to the defendant and others from engaging in similar conduct in the future.

In Montana, a judge or jury may award punitive damages for the sake of example and punishing a defendant (27-1-220, MCA). The law does not allow punitive damages recovered in an action arising from most torts of contract or breach of contract unless expressly provided in statute, and it does not prohibit recovery of punitive damages in a product liability action or in an action arising out of an insurance policy. Insurance coverage does not extend to punitive or exemplary damages unless expressly included by the contract of insurance (33-15-317, MCA).

Issue Number Nine: Structured Settlements/Periodic Payments

The terms "structured settlement" and "periodic payment" refer to the practice of spreading the payment of an obligation to the judgment creditor over an extended period (life of the judgment creditor or term of the injury or disability), instead of paying the obligation in a lump sum.

Title 25, chapter 9, part 4, MCA, governs periodic payment of damages over $100,000 for future medical treatment, care, or custody; for loss of future earnings; and for future pain and suffering of the judgment creditor. A party to an action for personal injury, property damage, or wrongful death may request that the court enter a judgment for periodic payment of future damages if the court finds it in the best interest of the claimant.

Issue Number Ten: Attorney Fees/Contingency Fees

Attorney fees refer to compensation received by attorneys for their professional services. Contingency fees are one form of attorney fees and are paid by the plaintiff to the plaintiff's counsel for services and costs. Fees are usually contingent upon the plaintiff winning the lawsuit and on the dollar amount of the total award. If the plaintiff loses, the attorney may not receive any compensation. Contingency fees are usually based on a percentage of the total award and are contractual agreements between the plaintiff and the plaintiff's counsel.

There is no general statute governing attorney fees, but there are many circumstances of fee-shifting. For example, 1993 legislation (Ch. 472, L. 1993), revising the Montana metal mine reclamation laws, requires an unsuccessful party challenging an issuance of permits to pay attorney fees and other costs to a prevailing or substantially prevailing party whenever the court determines an award is appropriate.

The state requires that when an attorney represents a claimant against the state or a political subdivision, a copy of the contract for employment must be filed. The District Court may regulate the amount of the attorney fees (2-9-314, MCA).

Issue Number Eleven: Reinsurance

Reinsurance is insurance for insurance companies. The insurance company pays the reinsurer a premium in exchange for which the reinsurer agrees to pay all claims above a certain amount or agrees to pay a portion of claims according to some formula. Reinsurance can insure insurance companies against very large claims. Insurance companies regularly reinsure all or part of their risks with reinsurance companies.

In 1993, legislation was passed in Montana creating a reinsurance program for insurance carriers that offer health care benefit plans to small employers in Montana. Under this program, a carrier may reinsure an entire small employer group or an individual eligible employee or dependent.

TESTIMONY

The Montana Trial Lawyers Association (MTLA) asked the Subcommittee to look at three issues: frivolous lawsuits, collateral source, and joint and several liability.[2] The MTLA believed that these topics were the three most important issues before the Subcommittee.

The Montana Defense Trial Lawyers recommended that the Subcommittee focus its resources on medical malpractice, as this was the real issue that led to the adoption of the study resolution.[3] The Montana Medical Association (MMA) also testified in favor of the Subcommittee studying medical malpractice. The MMA contended that one of the major driving forces in health care costs is the costs associated with medical liability.[4] The MTLA suggested that if the Subcommittee chose to study medical malpractice, the study should be conducted in conjunction with the Montana Health Care Authority's tort reform study.[5]

SUBCOMMITTEE DELIBERATIONS

Following presentation of the staff papers and the testimony from interested persons, the Subcommittee engaged in a discussion of the issues. The staff presented three options to the Subcommittee:

(1) conduct a study of each of the issues listed in the study resolution;

(2) select a few issues to study; or

(3) decide that none of the issues needs to be addressed legislatively.

The staff stressed to the Subcommittee that selecting Option 3 did not mean that the Subcommittee was abrogating its responsibilities. If the Subcommittee believed that none of the issues needed further study, the Subcommittee could make that their recommendation. The Subcommittee members agreed that it was not necessary to study every issue and that it would be more productive to concentrate on one or two issues.

Each member expressed an interest in studying medical malpractice. Other issues that attracted some interest included frivolous lawsuits, punitive damages, and the collateral source rule. However, only medical malpractice gained consensus and, thus, became the focus of study.

The Subcommittee's interest in medical malpractice stemmed in part from the failure of House Bill No. 346 in the 1993 session. That failure ultimately led to passage of the study resolution creating the Subcommittee. As originally introduced, House Bill No. 346 would have regulated medical malpractice claims and recoveries by limiting noneconomic damages, limiting plaintiff's attorney contingency fees, limiting health care provider liability, and shortening the statute of limitations on medical malpractice actions.

As a result of its deliberations, the Subcommittee voted to devote the remainder of the interim to a study of medical malpractice, in conjunction with the Montana Health Care Authority.[6]

ENDNOTES

1. Connie Erickson, Susan Byorth Fox, and David Niss, Issues Before the Joint Interim Subcommittee on Insurance Issues, Montana Legislative Council, December 1993, p. 24.

2. Joint Interim Subcommittee on Insurance Issues, Minutes, January 7, 1994, Montana Legislative Council, Exhibit #4.

3. Ibid., p. 5.

4. Ibid., p. 13.

5. Ibid., p. 6.

6. Ibid., p. 17.

CHAPTER THREE
MEDICAL MALPRACTICE

MONTANA

Medical Malpractice Information

In assessing the medical malpractice climate in Montana, the Subcommittee staff identified three important areas in which to gather information: claims, settlements or awards, and premium rates. A review of the statutes revealed three provisions relating to medical malpractice information in Montana. In addition, the staff obtained information from the Montana Medical Association and from insurance carriers.

MONTANA MEDICAL LEGAL PANEL

A provision of the Montana Medical Legal Panel Act, 27-6-703, MCA, states that the director of the Panel shall maintain records of all proceedings before the Panel and that records are to be used "solely for the purpose of compiling statistical data and facilitating ongoing studies of medical malpractice in Montana". The Panel issues regular reports using the statistical data.

BOARD OF MEDICAL EXAMINERS

Professional liability insurers are required by 37-3-402, MCA, to report each claim for alleged professional negligence against their insureds to the Board of Medical Examiners (Board) within 30 days after receiving notice of the claim. A final settlement resolving the claim in favor of the claimant must also be reported. The information is reported on a claim-by-claim basis. There is no statutory requirement for this information to be used by the Board, although if the Board finds evidence of three payouts over a 5-year period for a single physician, the physician is "flagged" for investigation.

In response to a Montana Trial Lawyers Association lawsuit, the Board staff compiled individual claim data by year and by whether each claim was a verdict or a settlement. The names of the insurance companies and the physicians identified for each claim were removed and replaced by codes. The information on claim data was provided to the Subcommittee staff.

Concerns for the rights of privacy for the physician, the insurance company, and the patient precluded the Board staff from providing the Subcommittee staff with complete information. The issues of the right to privacy versus the public right to know may potentially be litigated. The amount of information that is accessible is significant in the ability to determine the medical malpractice situation in Montana.

When the Subcommittee staff made their report on medical malpractice in April 1994[7], the information collected by the Board was maintained on paper in file cabinets. By August 1994, the insurance companies, at the request of the Board, had provided the Board with complete data from the past 10 years and the Board staff had created a new data base. The information used in this chapter is the information that was available to the Subcommittee between April and August 1994.

Information regarding physician incompetence or unprofessional conduct must be reported to the Board by a licensed physician, a professional standards review organization, or the Montana Medical Association or any component society of the Association (37-3-401, MCA). A report on the prohibition or limitation on practice by a hospital or health care facility is also required to be submitted to the Board (37-3-403, MCA). Because the public policy issue of medical malpractice, generally, was the Subcommittee's focus, rather than specific incidents of physician or health facility malpractice, the Council staff did not examine this data.

COMMISSIONER OF INSURANCE

Insurance companies that issue professional liability insurance are required by 33-23-311, MCA, to report annually to the Commissioner of Insurance (Commissioner). This report includes information on claims and lawsuits filed against insureds, the final disposition of the claims and lawsuits, and the monetary amount of settlements and awards. There is no requirement for the Commissioner to use or compile the information unless an "appropriate licensing authority" requests the information. If the information is requested, the Commissioner must provide the requested information within 60 days. The information from the reports is not stored in a computer data base, but is in paper form filed in the Capitol.

The Subcommittee staff gathered and analyzed information from all of the available sources. However, the staff discovered that the available information was incomplete and difficult to verify. The information was not in a form that readily lent itself to analysis. Also, the information from the Board and the Commissioner, although not directly comparable, did not seem to indicate full compliance with the reporting requirements of either the Board or the Commissioner.

QUESTIONS AND CONCERNS

Because the data appeared incomplete and was difficult to work with, it was used only to illustrate trends in medical malpractice. Some of the concerns that were raised by the problems with the information were:

(1) If reporting is not in compliance with statute, does there need to be a more explicit enforcement provision in the statutes?

(2) If the agencies do not use this information or if it is not in a readily useable format, does the information still need to be collected? Should the agencies be statutorily required to maintain the information in a computer data base, to compile reports, and to use the information?

(3) There are a large number of claims reported to the Board that are settled without any monetary compensation. Are these claims

frivolous? What does a settlement without monetary compensation mean? Is there monetary compensation for which the amounts are simply not being reported?

(4) There is no way to track individual claim data through the system. Although the Montana Medical Legal Panel (Panel) does a survey of cases after it completes the Panel process, there is no mandate for the followup information to be gathered or used. How can the success of the Panel be independently evaluated?

(5) The data is not comparable between the three sources. How do the Panel findings match the information reported to the Commissioner or the Board? The Board's data does not show any verdicts, although the Commissioner's data does. Also, the dollar amounts of "settlements" do not match.

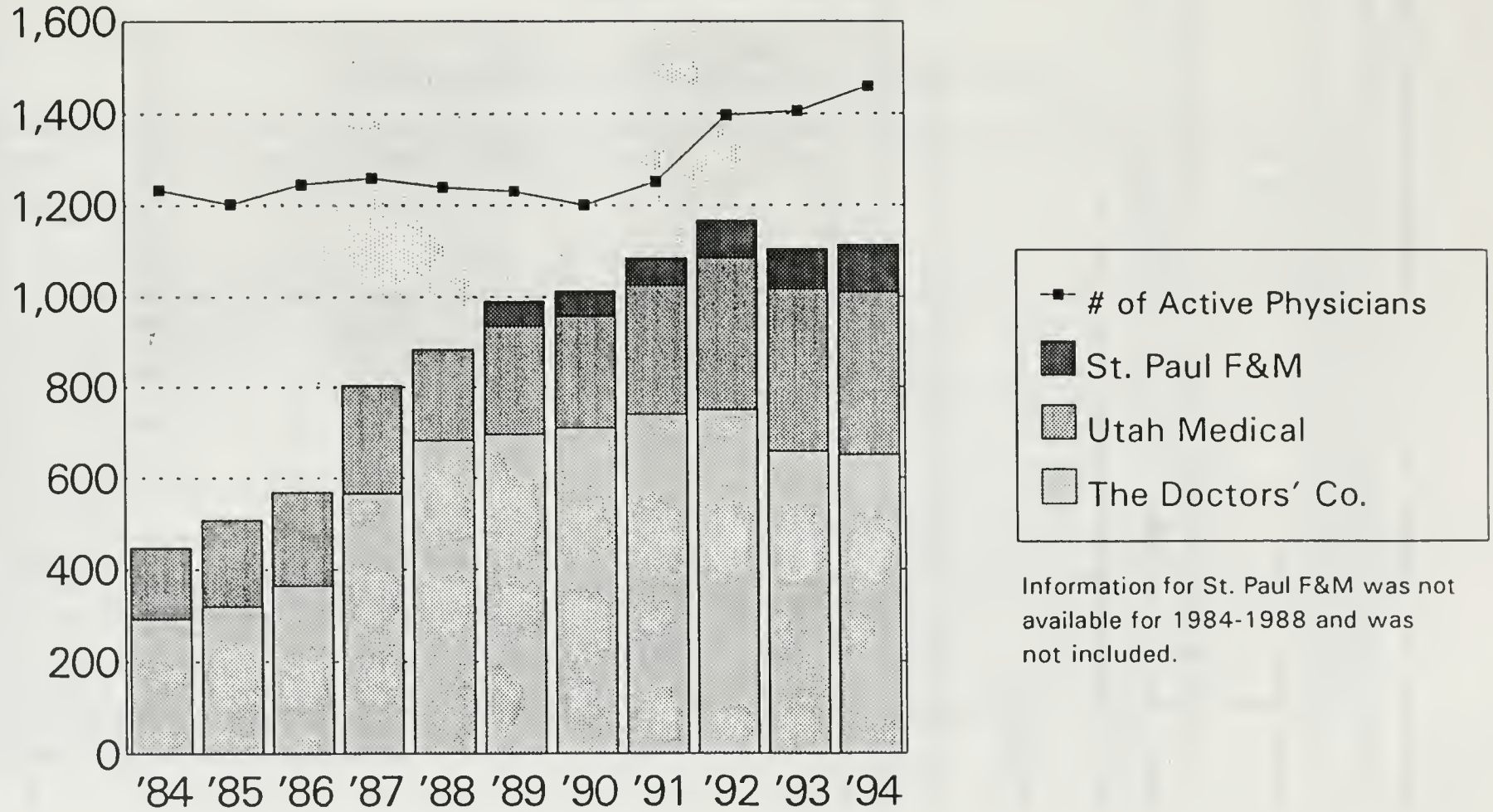
In essence, the data raised more questions than it answered. The Subcommittee staff used the information to ascertain possible trends and to look at the general medical malpractice climate, although steadfast conclusions could not be made. The information is only as good as the data from which it was compiled and analyzed. Consequently, the staff had serious reservations regarding the data's accuracy, completeness, and comparability.

THE NUMBER OF ACTIVE PHYSICIANS IN MONTANA AND THE THREE LARGEST INSURANCE CARRIERS

Chart 1 illustrates the number of active physicians in Montana and the number of physicians insured by the three professional liability insurance carriers writing the bulk of physician coverage policies in Montana. The information was obtained from the Montana Experience Professional Liability Insurance exhibits submitted annually to the Commissioner. The Montana Medical Association provided the physician data; as of March 15, 1994, there were 1,460 active physicians in Montana.

According to information received from The Doctors' Company, there were 1,467 active physicians in Montana. The Doctors' Company information also provided data on who carries the professional liability insurance for these physicians: 76% are insured by the three largest professional liability carriers for physicians in Montana--The Doctors' Company, Utah Medical Insurance

Chart 1
Number of Insured Physicians for Three Largest Companies and Number of Active Physicians in Montana



Information for St. Paul F&M was not available for 1984-1988 and was not included.

Insurance source: Commissioner of Insurance
Physician data: Montana Medical Association

Association (Utah Medical), and St. Paul Fire and Marine Insurance Company (St. Paul); 11% are insured by the government or through a hospital affiliation; 7% are insured by PHICO, Inc., through the Billings Clinic; and 6% are insured through other carriers.

The number of "bare" physicians, or those who are uninsured, is unknown. An Alaska analysis of medical malpractice reported that 5% of physicians nationwide are uninsured.

PREMIUMS

Table 1 and Table 2 present information provided by The Doctors' Company and Utah Medical listing the annual premium rates in the highest experience category*, with limits of coverage at $1 million per occurrence and $3 million per year.

* "Experience category" means the number of years a physician has been in practice; i.e., fourth year or more for The Doctors' Company and fifth year or more for Utah Medical.

TABLE 1

MONTANA ANNUAL PREMIUM RATES FOR THE DOCTORS' COMPANY

Fourth year or more experience category
$1 million per occurrence/$3 million per year limits of coverage

YEAR -- SPECIALTY	1994	4/1/92	1/1/91	9/1/90	4/1/88	1/1/83	Percent change from 1983 to 1994	Percent change from 1988 to 1994
Family Practice (no OB)	$6,012	$6,012	$6,012	$6,012	$9,160	$1,897	+217	-34
Family Practice (OB)	20,880	20,880	20,880	20,880	25,484	4,489	+365	-18
General Surgery	18,697	18,697	18,697	18,697	22,804	7,556	+147	-18
Internal Medicine	6,463	6,463	6,012	6,012	7,332	1,897	+241	-12
OB/GYN	31,900	31,900	37,000	39,036	47,608	8,884	+259	-33
Pediatrics	7,509	7,509	7,509	7,509	9,180	1,117	+572	-18
Highest: Neurosurgery	40,076	40,076	40,076	40,076	48,872	8,884	+351	-18
Lowest: Admin, Derm, Psychiatry	3,349	3,349	3,349	3,349	4,084	1,117	+200	-18

These rates do not reflect discounts or any exceptions given to individual physicians.
Source: The Doctors' Company

TABLE 2

MONTANA ANNUAL PREMIUM RATES FOR UTAH MEDICAL INSURANCE ASSOCIATION

Fifth year or more experience category
$1 million per occurrence/$3 million per year limits of coverage

YEAR -- SPECIALTY	1/1/93	7/1/92	1/1/91	1/1/90	1/1/88	1/1/87	Percent change from 1987 to 1988	Percent change from 1988 to 1993
Family Practice (no OB)	$3,585	$3,203	$3,585	$3,939	$4,169	$3,694	+13	-14
Family Practice (OB)	16,385	14,760	16,385	20,185	21,475	16,436	+31	-24
General Surgery	18,343	15,523	18,343	25,249	26,930	23,828	+13	-32
Internal Medicine	3,585	3,203	3,585	3,939	4,169	3,694	+13	-14
OB/GYN	30,479	26,607	30,479	42,132	44,971	39,785	+13	-32
Pediatrics	3,585	3,203	3,585	3,939	4,169	3,694	+13	-14
Highest: Neurosurgery	30,479	28,591	30,479	42,132	59,891	52,982	+13	-49
Lowest: Allergy, Psychiatry, Physical Medicine and Rehab	3,020	3,027	3,020	3,714	3,927	3,480	+13	-23

These rates do not reflect discounts or any exceptions given to individual physicians.
Source: Utah Medical Insurance Association

All physicians within a specialty pay a medical malpractice premium rate determined by the number of years that they have been practicing, not by their medical malpractice experience. Some doctors may be given discounts or other deductions that are not reflected in these charts.

Premium rates for The Doctors' Company increased by 147% (General Surgery) and 572% (Pediatrics) from 1983 to 1994. Information shows a large increase in 1988 (no data for 1984 through 1987), with rates decreasing in 1990 and remaining stable through 1994.

Utah Medical premium rate information also shows 1988 as the highest year for rates. Its rates also have decreased since 1988. Rates for 1993 are the same as 1991 rates, which are close to the 1987 rates, with a brief dip in rates for the last 6 months of 1992.

Table 3 reports direct premiums earned and direct losses incurred for all companies that carry medical malpractice insurance, according to reports of the National Association of Insurance Commissioners (NAIC). The table also reports the "pure loss ratio". The pure loss ratio is the direct losses incurred expressed as a percentage of earned premiums and does not include any expenses incurred, such as overhead and legal expenses, because this information was not available. This table is only intended to illustrate the range of the pure loss ratio, from 21% to 76%, with great variations each year.

TABLE 3

Total Earned Premiums Versus Incurred Losses and Pure Loss Ratio

All Companies - Medical Malpractice Insurance 1988-1992

Year	Direct Premiums Earned	Direct Losses Incurred	Pure Loss Ratio
1988*	$14,600,054	$3,519,230	24%
1989	18,708,576	10,548,945	56%
1990	19,242,363	4,105,239	21%
1991	16,235,333	6,440,253	40%
1992	15,552,020	11,744,818	76%

*Does not include Utah Medical Insurance Association

Direct Premiums Earned - the portion of the policy premium allocable to the expired portion of the policy term.

Direct Losses Incurred - the sum of paid losses and loss reserves for all claims during a particular time period.

Pure Loss Ratio - direct losses incurred expressed as a percentage of earned premiums.

Source: Commissioner of Insurance, NAIC reports

CLAIMS AND LAWSUITS FILED -- PHYSICIANS ONLY

Chart 2 illustrates the inconsistency of the data with which the Subcommittee and its staff had to work. The Professional Liability Insurance Experience exhibits submitted to the Commissioner reflect more claims made than the claims reported in the data received by the Board. The Board staff is attempting to ensure the accuracy of its records and has requested information from the insurance carriers for the years 1984 to the present to compile in a new data base. There is no verification of the data submitted to the Commissioner. Information from the Montana Medical Legal Panel shows yet a different number of claims made against physicians.[8] This discrepancy may be because of different reporting requirements, different definitions, or different

levels of compliance. There is no method by which to verify these numbers or compare them to each other. Overall, the claims rate is approximately 10% of claims per 100 doctors, which is close to the Montana Medical Legal Panel's estimates.

Chart 3 illustrates the difference between the number of claims and the number of lawsuits filed. There is a great range in lawsuits as a percentage of claims, from 9% in 1984 and 1988 to a high of approximately 45% in 1990 and 1991 and decreasing to 13% in 1992 and 1993. If a comparison is made between the number of insured physicians involved in lawsuits and the number of physicians practicing in the state, on the average, 2% to 3% of physicians are involved in lawsuits. This does not take into account any physician who may be involved in more than one lawsuit. The year 1991 seems to have been a low year and the year 1992 a high year for claims, but 1993 compares to the average of the other years. Lawsuits peaked in 1990 and dropped to below 1988 levels in 1993.

CLAIMS AND LAWSUITS SETTLED

Chart 4 and Chart 5 are derived from Board data. Although the data may be incomplete, some trends are discernible. Chart 4 shows the total number of reported claims settled and the number of claims settled with a payment. These claims are any claims made to a physician's insurance company. This chart illustrates that not all claims end in a payment and that many claims are settled with no monetary settlement (50% on average, with a range from 28% in 1987 to 87% in 1992).

Because the information submitted to the Board is on a claim-by-claim basis, the average and median settlement of the claims settled with a payment can be calculated. Chart 5 does not include the claims for which no payment was made, so, in dollars, a total average or median amount of all claims would be much lower. The amount of claims paid includes all types of damages as well as attorney fees because a breakdown between economic and noneconomic

damages is not available. The data table at the bottom of Chart 5 relates the highest settlement made for each year. As illustrated, the exceptional, high, multimillion-dollar settlement skews the average, but the median payment (the point at which half of the payments are above and half below) is much lower than the average. The average claim payment for the 9-year period is $105,656, and the 9-year median claim payment is $27,500. (Note that this dollar figure is lower than the average payment of lawsuits filed and settled without trial--Table 4.) These figures may be useful in discussing caps on damages and may indicate that some sort of cap would help with these few high settlements; however, the majority of the settlements are considerably lower than the $250,000 cap often proposed. Consequently, instead of lowering the ceiling on settlements as caps are intended, the floor may be raised. The dollar amounts in Chart 5 include all damages--economic, noneconomic, and punitive. Specific information on noneconomic damages, those that are most often capped, is unavailable.

Chart 5 and Chart 6, although the numbers are difficult to compare, lead one to the same conclusion that most settlements in Montana are below the $250,000 usually proposed as a cap on damages. The highest yearly averages are still at or below $200,000, and the cumulative averages are below $100,000. The yearly averages illustrate that each company experiences bad years, but not consistently for each company each year. Also, St. Paul and Utah Medical have lower numbers of insureds and claims, and therefore a single high claim may skew the averages, as can be seen in 1985 for Utah Medical and in 1990 for St. Paul. Over a 9-year period, the cumulative average are even lower than the yearly averages.

Table 4 illustrates a comparison of the number of claims versus lawsuits that these three insurance companies experienced over a 10-year period. Note that each category does not necessarily include the same actual claims, as each claim will open and close during different years, but rather the aggregate of annual experience over a 10-year period. In the "Total" column, over a 10-year period, 1,393 claims were made, 300 lawsuits were filed (a 1-to-5 ratio), 132

lawsuits were settled without trial (for an average settlement of $123,000), 19 lawsuits (1%) went to trial, and 4 lawsuits resulted in verdicts for the plaintiff (0.3%). Comparing this information to the Board's information indicates that a higher settlement is reached if a lawsuit is filed; however, it is not the judgment or verdict that determines the settlement, but the compromise before the trial.

TABLE 4

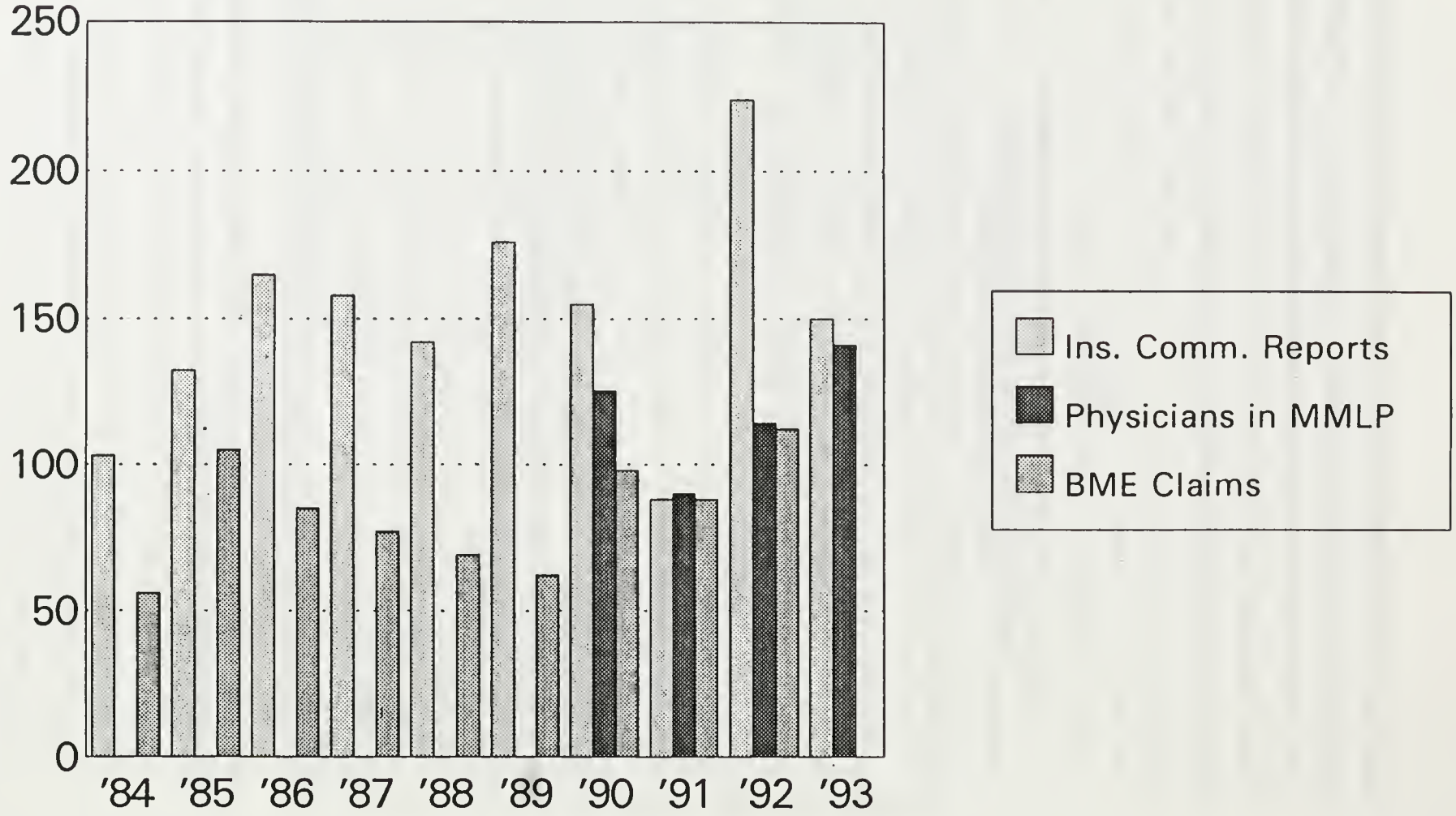
Comparison of the Three Largest Professional Liability Insurance Carriers' Claims and Lawsuit Experience Over a 10-Year Period 1984-1993

	Doctors' Company	Utah Medical	St. Paul F&M	Total
Number of claims made	976	162	255	1,393
Number of lawsuits filed	159	56	85	300
Previously filed and dismissed without settlement or trial	53	13	21	87
Previously filed and settled without trial	41	65	26	132
Average settlement	$214,181	$68,918	$116,096	$123,330
Went to trial	8	6	5	19
Judgment or verdict for the plaintiff	3	1	0	4
Judgment or verdict for the defendant	4	5	5	14
Other	1	0	0	1

All categories reported on an annual basis for the calendar year next preceding.

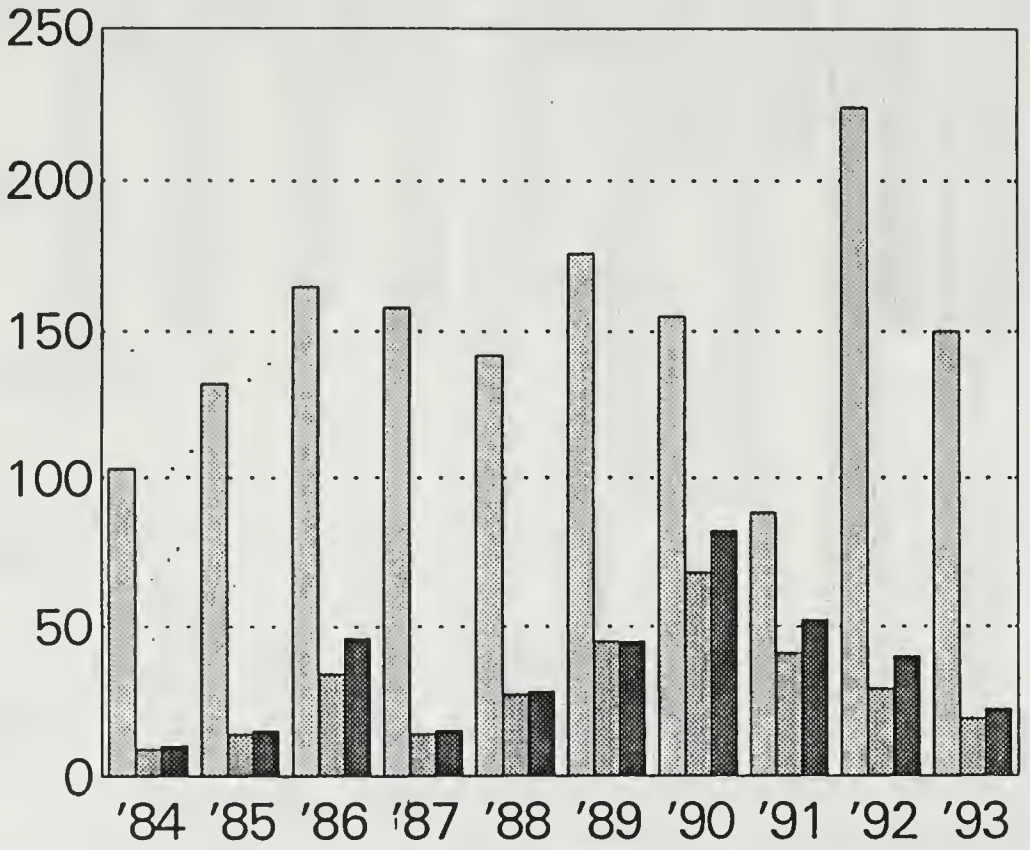
Source: Commissioner of Insurance, Insurance Company Experience Professional Liability Insurance Exhibit

Chart 2
Number of Claims Made Against Physician Insureds and Against Physicians in Med/Legal Panel Claims and Claims Filed With the Board of Medical Examiners



Sources: Board of Medical Examiners (BME)
Commissioner of Insurance (3 companies with largest % professional liability insurance)
Montana Medical Legal Panel (MMLP)

Chart 3
Number of Claims Made Against Insureds and Number of Lawsuits Filed Against Insureds



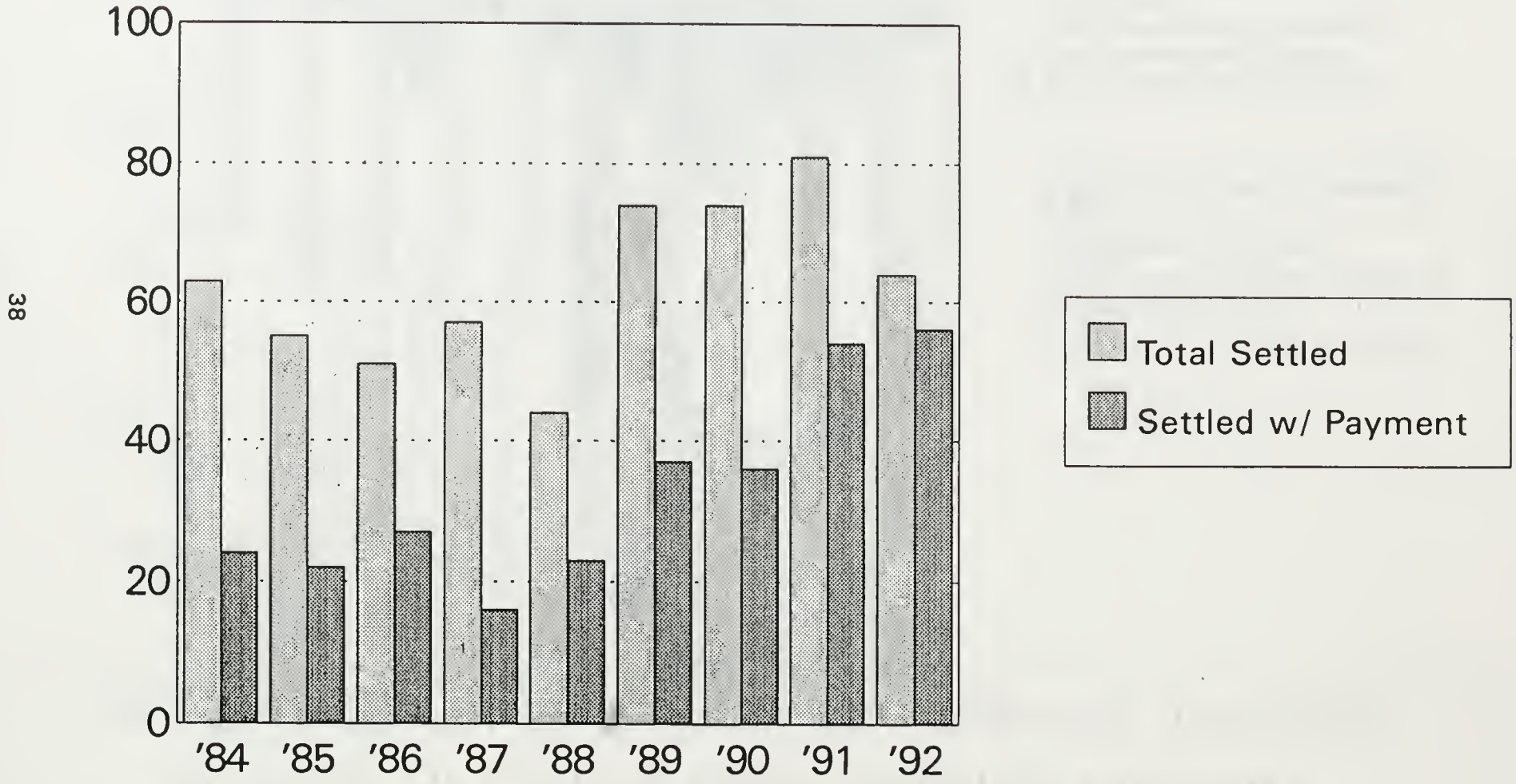
% of Active MDs	0.8	1.2	3.7	1.2	2.2	3.7	6.8	4.1	2.8	1.6

Claims Made
Lawsuits Filed
Insureds in Lawsuits

★ St. Paul data is abnormally high for 1986 and may skew the lawsuits filed and the number of insureds in lawsuits data.
The Doctors' Company data for number of claims made for 1988 could not be used, and a 3-year average was substituted.

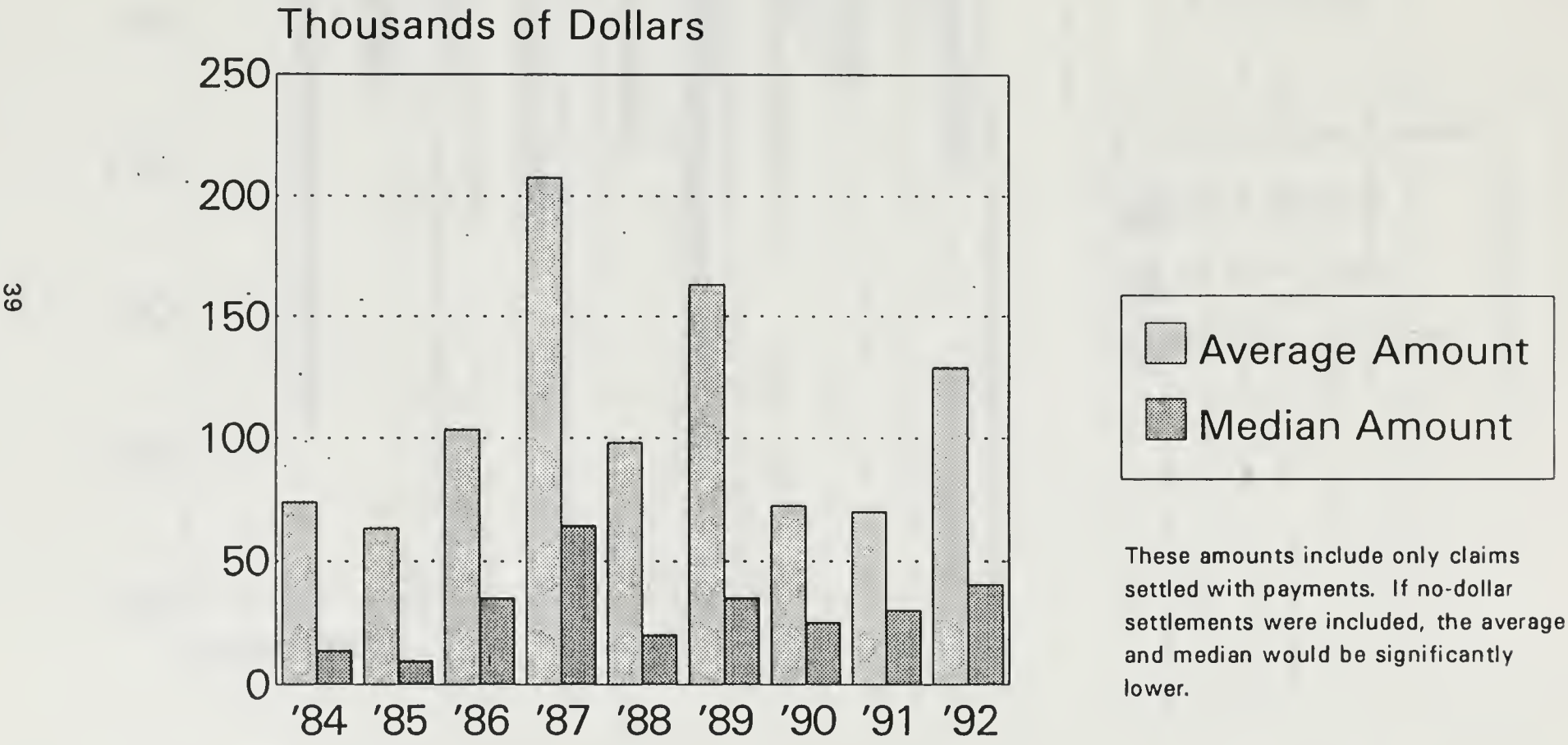
From three companies with largest percentage of physician liability insurance
Insurance source: Commissioner of Insurance
Physician source: Montana Medical Association

Chart 4
Number of Claims Settled and Number of Claims Settled With Payment



Source: Board of Medical Examiners

Chart 5
Average and Median Amount of Claims Settled With Payment

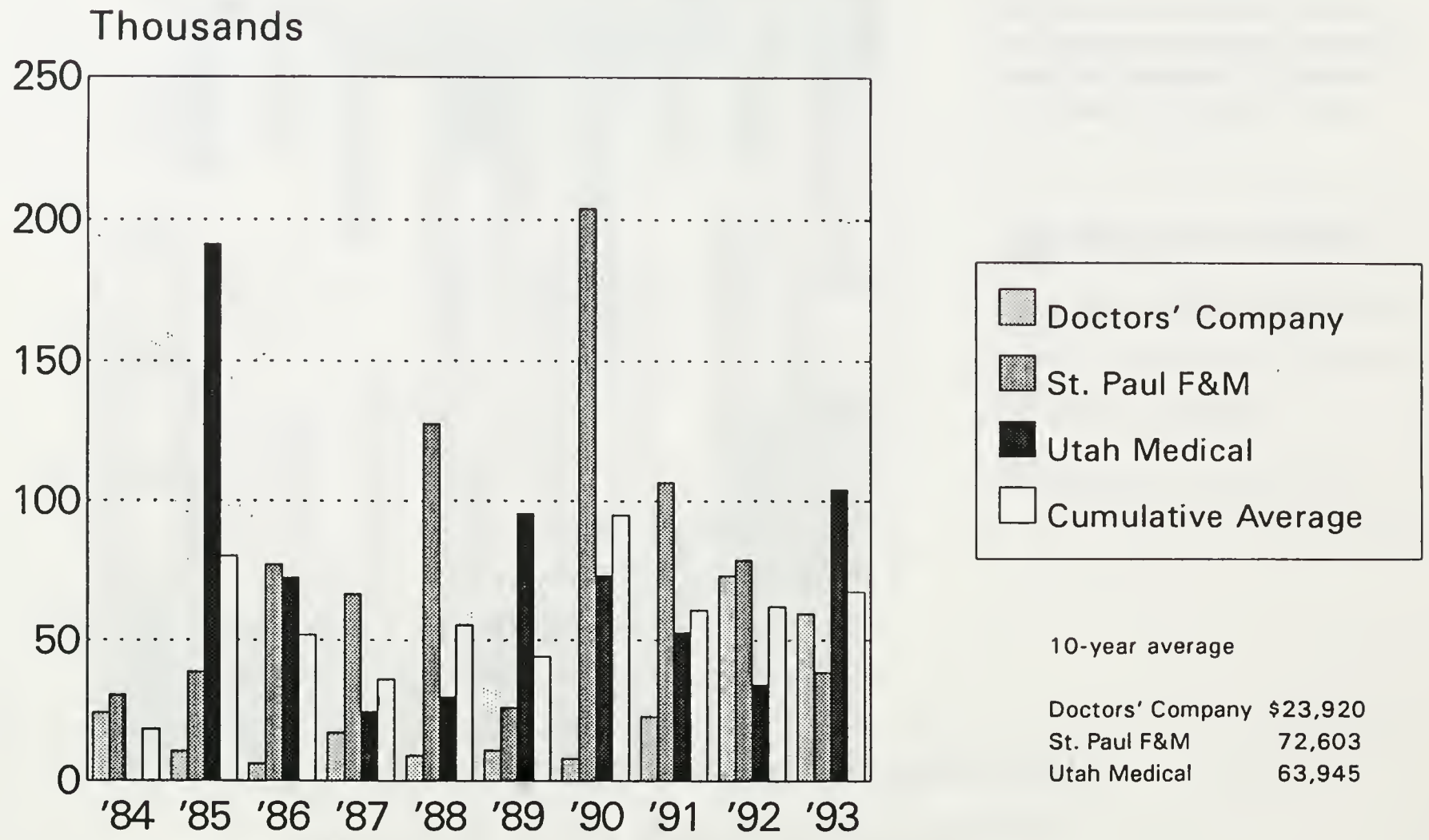


	'84	'85	'86	'87	'88	'89	'90	'91	'92
Highest Settlement	675	320	600	1,000	750	3,300	500	383	2,400

These amounts include only claims settled with payments. If no-dollar settlements were included, the average and median would be significantly lower.

Source: Board of Medical Examiners

Chart 6
Average Claim Paid by Three Largest Companies



10-year average

Doctors' Company	$23,920
St. Paul F&M	72,603
Utah Medical	63,945

Source: Commissioner of Insurance

CONCLUSION

The data does not support claims that there is a medical malpractice crisis in Montana. Professional liability insurance for health care providers is available at competitive rates. Very few claims result in lawsuits, and those that do are settled, more often than not, in favor of the defendant. Cases resulting in million-dollar settlements are rare. If the perceived crisis is one in which the cost of premiums is assumed to be too high and, therefore, is a variable in the availability of physicians statewide or a related crisis in the cost of health care in general, those issues were beyond the scope of the Subcommittee's study and were not addressed.

The other issue raised by the medical malpractice study was the condition of the available information. If continued data collection on medical malpractice claims is considered important, statutory requirements on collection, verification, compilation, use, and reporting could be proposed and the resources necessary to accomplish those tasks could be ascertained. Comparability of data, enforcement of compliance, and the ability to follow claims from submittal to final resolution also need to be addressed if the data collection is valued.

Although the Subcommittee was made aware of the limitations of the data used in the study, as well as the general condition of the information, no action was taken to address the situation. The Subcommittee believed that statutory requirements were not appropriate. Any initiatives to correct the problems should come from those agencies responsible for collecting and maintaining the information.

SURROUNDING STATES

Statutory Provisions

NORTH DAKOTA

Damages: North Dakota law allows for the awarding of both economic and noneconomic damages. In awarding compensation, the court must make separate findings on the amount of past economic damages, future economic damages, and noneconomic damages. Any person who is responsible for the payment of any portion of an award for economic damages may request the court to review the reasonableness of the award. If the court finds the award to be unreasonable, it shall reduce the award to reasonable economic damages. Exemplary or punitive damages are allowed. However, exemplary damages may not be awarded if the claimant is not entitled to compensatory damages. The limit on exemplary damages is two times the amount of compensatory damages or $250,000, whichever is greater (N.D.C.C. Chapter 32-03.2).

Collateral source rule: The law allows for a reduction in damages for collateral source payments. In order to receive this reduction, the party responsible for the payment of the damages must apply to the court. A collateral source is defined as "any sum from any other source paid or to be paid to cover an economic loss which need not be repaid by the party recovering economic damages". It does not include any benefit purchased by the party recovering the damages, such as disability insurance or retirement benefits. A jury may not be informed of any potential reduction of economic damages from collateral source payments (N.D.C.C. § 32-03.2-06).

Periodic payment of future damages: If the injured party claims future economic damages for continuing custodial care required for more than 2 years, the court may make a special finding of the amount awarded for this care and make provision for the periodic payment of the award. The obligation

of periodic payments terminates upon the death of the injured person (N.D.C.C. § 32-03.2-09).

Mutual insurance company: In 1983, the North Dakota Legislature created the North Dakota Medical Malpractice Mutual Insurance Company. The purpose of this company was to indemnify persons who suffered injuries arising from the care or lack of care by physicians and to provide liability insurance to physicians who were having a difficult time obtaining insurance. The company was to be funded by a one-time tax of $500 levied on every licensed physician in the state. Physicians who choose to join the company would also pay a membership fee. Once the fee was paid, the physician would be insured for up to $500,000 for each claim and up to $1,000,000 for all claims in a policy period. For claims in excess of these amounts, the insured would be immune from all liability. Implementation of the statute governing the company requires a majority vote of the State Board of Medical Examiners (N.D.C.C. Chapter 26.1-14). To date, the statute has not been implemented.[9]

Expert opinion: North Dakota law requires a claimant to obtain an expert opinion to support the allegation of professional negligence. The claimant has 3 months in which to provide this opinion or the action may be dismissed (N.D.C.C. § 28-01-46).

SOUTH DAKOTA

Collateral source rule: South Dakota allows evidence of payments from collateral sources to be admitted in a malpractice action, provided that the sources are not subject to subrogation and were not purchased privately by the claimant or the claimant's family. The law is silent on whether or not a damage award can be reduced because of a collateral source payment (SDCL § 21-3-12).

Periodic payment of future damages: Any party to an action for bodily injury may request the court to grant the periodic payment of a damage award. All

parties to the action must agree to the request. However, periodic payments are mandatory for damage awards in excess of $200,000 (SDCL Chapter 21-3A).

Cap on damages: There is a cap of $1 million on the total damages that may be awarded in a medical malpractice action. This includes economic as well as noneconomic damages (SDCL § 21-3-11). However, the cap is currently under court challenge.[10]

Arbitration agreements: Hospitals or physicians and patients may enter into voluntary arbitration agreements in which the patient agrees to the neutral arbitration of any medical malpractice issue that may arise and, in turn, gives up the right to a trial. The agreement can be terminated by either party at any time. A hospital or a physician may not require an arbitration agreement as a prerequisite to treatment.

Hearings before the arbitration panel occur in two stages. In the first stage, the panel determines liability. If the panel finds liability, there is a 30-day waiting period in which the parties try to agree on damages. If after 30 days, an agreement has not been reached, the panel holds a second hearing to determine the amount of damages, if any, to be awarded (SDCL Chapter 21-25B).

Malpractice claim reporting: South Dakota requires insurance companies that issue medical malpractice insurance to report certain information to the state Insurance Division. At least twice a year, each company must report all claims for medical malpractice made against any of its insureds. In addition, each insurance company must report on the disposition of a claim within 30 days of a judgment, settlement, or dismissal. The latter information is then forwarded by the Division to the appropriate state professional licensing board.

Except for transmission to a licensing board, the information collected by the Insurance Division is kept confidential and can be released only for bona fide

research or for educational or legislative purposes and, even then, only with the approval of the Director of the Division (SDCL Chapter 58-23A).

WYOMING

Medical liability compensation fund: The medical liability compensation fund provides insurance coverage for Wyoming physicians in excess of the coverage purchased by the physician personally. To qualify, a physician must carry insurance coverage of at least $50,000 per occurrence and pay an annual surcharge of 150% of the cost of a $50,000 malpractice insurance premium. The surcharge is collected by the insurance company, in the same manner as premiums are collected, and then remitted to the Commissioner of Insurance for deposit in the compensation account. If an award or a settlement is made in excess of $50,000 on a malpractice claim, the excess amount will be paid from the compensation account, but not to exceed $1,000,000 in any calendar year for one or more awards or settlements against the physician. A settlement must be carried out through an agreement by the claimant, the insurance company, and the Commissioner of Insurance. If a claimant settles with an insurance company without including the Commissioner of Insurance in the settlement agreement, the claimant waives any claim for damages in excess of $50,000 (W.S. Title 26, Chapter 33 (1991)). The compensation fund has not been put into operation because of the fund's actuarial unsoundness.[11]

Medical review panel: The Wyoming Medical Review Panel Act sets up a procedure for the prescreening of medical malpractice claims. The Wyoming Medical Review Panel (Panel) operates in much the same way as the Montana Medical Legal Panel. Any claim alleging medical malpractice on the part of a health care provider must be reviewed and decided by the Panel before an action can be commenced in court. The deliberations of the Panel are confidential; the Panel's decision, however, is not binding nor is it admissible in any subsequent court action (W.S. Title 9, Chapter 2, Article 15).

In 1988, the Panel was declared unconstitutional by the Wyoming Supreme Court. In that decision, the court ruled that the law was not rationally related to the protection of the public health or the economic or social stability of the state. The court also ruled that the legislation protected one class of people from financial difficulties while diluting the constitutional rights of another class of people. See Hoem v. State, 756 P.2d 780 (Wyo. 1988).

Cap on damages: The Wyoming Constitution prohibits the placing of limits on damages for personal injury (Article 10, Sec. 4).

IDAHO

Cap on damages: Idaho law caps noneconomic damages at $400,000. However, each July 1, the cap is increased or decreased in accordance with the percentage amount of increase or decrease in the average annual wage, as determined by the Idaho Industrial Commission. The cap does not apply to an action arising out of willful or reckless misconduct or to an action that would constitute a felony under federal or state law (Idaho Code § 6-1603).

Punitive damages: A claimant must prove by a preponderance of evidence that punitive damages are deserved because of oppressive, fraudulent, wanton, malicious, or outrageous conduct on the part of the defendant. The cap on noneconomic damages does not apply to punitive damages (Idaho Code § 6-1604).

Collateral source rule: An award can be made only for damages in excess of amounts received by a claimant from collateral sources. Collateral sources do not include sources recoverable under subrogation rights or benefits from a life insurance contract. Evidence of payment from collateral sources is admissible after an award has been made. An award must be reduced by the court to the extent that the award includes compensation from collateral sources (Idaho Code § 6-1606).

Periodic payment of future damages: A court may provide for the periodic payment of a damage award that exceeds $100,000. If either party requests a periodic payment, each party must submit a proposal stating the reasons why the request is appropriate or inappropriate and the manner and method of the future periodic payments (Idaho Code § 6-1602).

Prescreening panel: Idaho requires all medical malpractice claims to be reviewed by a prelitigation panel as a prerequisite to litigation. The panel's proceedings are confidential, and its decisions are nonbinding. A panel decision is inadmissible in any subsequent court action (Idaho Code Title 6, Chapter 10).

Expert witness: In any medical malpractice case, the plaintiff must prove the negligent failure of the health care provider to meet the applicable standard of health care practice of the community in which the care was or should have been provided. The applicable standard of care and the defendant's failure to meet that standard must be established by the testimony of one or more knowledgeable and competent expert witnesses (Idaho Code § 6-1013).

TABLE 5

SELECTED STATUTORY PROVISIONS FOR MEDICAL MALPRACTICE

Idaho, Montana, North Dakota, South Dakota, & Wyoming

STATE	COLLATERAL SOURCE	PERIODIC PAYMENT	CAPS ON DAMAGES	REVIEW PANEL	OTHER
ID	M	D over $100,000	$400,000 on noneconomic damages	M nonbinding	
MT	M	D over $100,000	None	M nonbinding	
ND	D	D	punitive 2 x amount of damages or $250,000	None	mutual insurance company
SD	D	M over $200,000	$1,000,000 on total damages under court challenge	None	arbitration agreements
WY	None	None	None	M nonbinding overturned by court	patient compensation fund

KEY: D = Discretionary M = Mandatory

Medical Malpractice Insurance Rates

Medical malpractice insurance rates vary by the state or locality in which the physician practices, by the specialty or subspecialty of practice, and sometimes by the number of hours worked, years in practice, and attendance at risk management training sessions. Malpractice insurers almost never base their rates on the specific experience of an individual physician.[12] The rates vary by years of experience, but these experience categories range only from 1 year to 4 or 5 years, depending on the insurance company. The last year or highest experience category is often referred to as the "mature rate". Coverage is provided on a per-incident basis and on an annual aggregate basis. For example, coverage of $1M/$3M means $1 million per incident and $3 million per year.

Table 6 shows the mature rates for $1M/$3M coverage for selected specialties for Montana and four neighboring states. In each case, the rates are those of the major medical malpractice insurance carriers in that particular state.

TABLE 6

MEDICAL MALPRACTICE INSURANCE RATES
Mature Rate
$1M/$3M Policy Limits

SPECIALTY	IDAHO (TDC)	MONTANA (TDC) (UMIA)	NORTH DAKOTA (TDC) (MMIC) (SPF&M)*	SOUTH DAKOTA (SPF&M)*	WYOMING (TDC)
Family Practice (no OB)	$6,490	$9,011 $6,862	$6,957 $6,083 $6,636	$4,401	$10,218
Family Practice (OB)	$15,247	$25,056 $16,385	$14,550 $8,516 $9,827	$5,778	$26,877
General Surgery	$15,206	$22,436 $18,343	$16,367 $10,543 $15,890	$7,154	$27,310
Internal Medicine	$5,706	$7,756 $3,585	$6,150 $4,866 $6,636	$4,401	$9,775
OB/GYN	$22,903	$35,728 $30,479	$26,239 $22,303 $38,921	$17,795	$42,275
Pediatrics	$7,168	$9,011 $3,585	$7,179 $4,055 $6,636	$3,024	$9,695
Highest: Neurosurgery	$35,588	$48,091 $30,479	$37,106 $36,496 $53,099	$27,967	$55,412
Lowest: Admin. Medicine	$4,605	$4,019 $3,020	$4,314 $2,839 $5,359	$2,473	$4,727
Allergy	$2,718	$4,019 $3,020	$3,076 $4,055 $5,539	$3,024	$4,920

Key: (TDC) The Doctors' Company (SPF&M) St. Paul Fire & Marine
(MMIC) Midwest Medical Insurance Co. (UMIA) Utah Medical Ins. Assoc.

* The SPF&M rates are for $1M/$1M policy limits.

In comparing the medical malpractice insurance rates of the five states, some general statements can be made.

Wyoming has the highest rates of all five states. However, the Wyoming Medical Society acts as a third-party administrator for The Doctors' Company in Wyoming. As a result, members of the Wyoming Medical Society who insure with The Doctors' Company receive a 20% discount on their insurance rates.[13]

South Dakota has the lowest rates of the five states. In the late 1980s, a court case in Minnesota against St. Paul resulted in the reduction of medical malpractice insurance rates in a number of states. In South Dakota, the reduction amounted to about 25%. Since that time, there has been no increase in the St. Paul rates in South Dakota, where St. Paul insures about 90% of the physicians and surgeons.[14]

In the three remaining states--Idaho, North Dakota, and Montana--the rates are higher or lower, depending upon the medical specialty and upon the company. No general trend can be observed.

Of the five states examined, two--Idaho and South Dakota--have caps on damages. However, it is unclear from this information whether the lower rates are directly related to the caps. In South Dakota, a more compelling reason is the court decision that resulted in a 25% reduction in rates in 1989. However, it is possible that the rates have remained low due, in some part, to the cap.

OFFICE OF TECHNOLOGY ASSESSMENT

In 1992-93, the Office of Technology Assessment (OTA) of the United States Congress conducted a study at the request of the House Committee on Ways and Means and the Senate Committee on Labor and Human Resources. The purpose of the study was to provide Congress with the most recent information on medical malpractice reforms in the states and to examine whether the

reforms reduced direct malpractice costs. The OTA selected six studies that employed similar statistical methods to analyze the impact of various state tort reforms on one or more malpractice cost indicators (the number of malpractice claims per physician; the amount of payment per paid claim; and the price of malpractice insurance) and that examined the impacts of tort reforms in two or more states. Among the reforms that were analyzed by these six studies were:

- establishing pretrial screening panels;
- limiting contingent attorney fees;
- requiring or allowing awards to be reduced by the amount of collateral payments;
- imposing caps on damage awards; and
- requiring or allowing periodic payments.

The examination of the six studies produced conflicting results. Nevertheless, the OTA was able to draw the following tentative conclusions:

- Caps on damage awards and mandatory collateral source offsets significantly reduced direct malpractice costs. However, a cap on total damages was shown to be the most effective, while the results of a cap on noneconomic damages were inconsistent.[15]
- Establishing pretrial screening panels showed mixed effects.[16]
- Limiting attorney fees and mandatory or discretionary periodic payments was not found to significantly reduce direct malpractice costs.[17]

The OTA study examined only the impact of tort reforms on direct malpractice costs. It did not examine their effects on physician behavior, the quality of patient care, and overall health care costs.

CONCLUSION

A cap on damages may have the effect of reducing malpractice insurance premiums; the OTA study suggests this possibility. However, analysis does not support the need to enact damage caps in Montana.[18]

Limits on attorney fees are not found in any of the states examined in the OTA study. Twenty-one other states do limit attorney fees by means of a sliding scale, a maximum percentage, or court approval or determination. The OTA study shows no significant impact on medical malpractice insurance premiums by limiting attorney fees.

It is difficult to isolate one single medical malpractice reform and say that that single reform lowered insurance premiums. Because each state has enacted various reforms and variations of the same reform, the only reliable way of determining the impact of a state's reforms on premiums is to analyze the medical malpractice provisions, the number of doctors, the number of doctors by medical specialty, the judicial climate, and other variables unique to each state.

ENDNOTES

7. Susan Byorth Fox and Connie F. Erickson, Medical Malpractice in Montana, Montana Legislative Council, April 1994.

8. Gerald J. Neely, Montana Medical Legal Panel: Claims Made Before the Medical Legal Panel 1977-1993, April 1994, p. 4.

9. Telephone conversation with Larry Maslowski, North Dakota Department of Insurance, June 22, 1994.

10. Impact of Legal Reforms on Medical Malpractice Costs (Washington D.C.: Office of Technology Assessment), p. 84.

11. Telephone conversation with Richard Johnson, Wyoming Medical Society, June 21, 1994.

12. Impact of Legal Reforms on Malpractice Costs, p. 13.

13. Telephone conversation with Richard Johnson.

14. Telephone conversation with Mike Saylor, South Dakota Department of Commerce and Regulation, June 22, 1994.

15. Impact of Legal Reforms on Malpractice Costs, p. 64.

16. Ibid., p. 72.

17. Ibid.

18. Medical Malpractice in Montana.

CHAPTER FOUR
SUBCOMMITTEE RECOMMENDATIONS

At its last meeting, on August 26, 1994, the Subcommittee considered a number of legislative proposals requested by interested persons and individual Subcommittee members. The proposals were divided into five categories: tort reform, insurance regulation, Montana Medical Legal Panel, health care providers, and other issues. The Subcommittee heard testimony, debated each proposal, developed conclusions, and made recommendations.

TORT REFORM

Limiting Medical Malpractice Contingency Attorney Fees[19]

The Montana Medical Association (MMA) proposed legislation to limit the amount of money that a plaintiff's attorney could receive for handling a case on a contingency fee basis. The limitation was based on a sliding scale, so that as the amount of damages increases, the percentage decreases.

Russell Hill, Montana Trial Lawyers Association (MTLA), testified that the MTLA opposed this bill. However, if the Subcommittee is interested in this legislation, then, in the interests of fairness, defense attorney fees should also be limited.

Jerry Loendorf, MMA, testified that this bill was not designed to limit claimants' access to court. The proposed limits would ensure that attorneys would receive adequate compensation for their work while making more money available to claimants.

Subcommittee members asked if the enactment of similar laws in other states resulted in a decrease in medical malpractice insurance premiums. No one could offer information confirming that premiums had dropped as a direct result of contingency fee limits. The Subcommittee took no action on the legislation.

Mandating the Periodic Payment of Future Damages of $100,000 or More in an Action for Personal Injury, Property Damage, or Wrongful Death.[20]

This proposal was suggested by the MMA. Current law applies to future damages of $100,000 or more and is discretionary on the part of the judge. This proposal would make mandatory the periodic payment of future damages in excess of $100,000, unless the judge found that periodic payment was not in the best interest of the claimant.

Gerry Neely, MMA, testified that this proposed legislation would be beneficial to both claimants and their attorneys. Claimants would not have to pay taxes on the periodic payments, and attorneys could stretch the receipt of their payments over many income years instead of one.

Russell Hill, MTLA, testified that this idea would increase the likelihood that claimants would be forced to accept periodic payments against their will. Also, it would force a trial judge to become a financial advisor for every claimant who comes before the court.

Subcommittee members expressed concern over the possibility that juries might be inclined to increase damage awards if this idea becomes law. Some members asserted that it was presumptuous of legislators and judges to tell people how to manage their own finances. The Subcommittee voted 6 to 2 not to approve the proposed legislation.

Limiting Medical Malpractice Noneconomic Damages to $500,000 for a Single Incident of Malpractice[21]

The proposed limitation on noneconomic damages advocated by the MMA would apply to a single incident of medical malpractice, regardless of the number of claimants, the number of health care providers, or the number of acts that allegedly caused the injury or death.

Jerry Loendorf, MMA, testified that the proposal applies only to noneconomic damages, such as emotional distress, that are difficult to cost out. He contended that by holding down the amount of awards, the cost of medical malpractice insurance will decrease.

Randy Dix, MTLA, testified in opposition to the damage caps. As expressed in the proposed legislation, the proposition did not exclude physical impairment or disfigurement. Concern was also expressed by Mr. Dix that some people who are injured by medical malpractice do not have economic losses that can be easily measured in terms of dollars; however, they are entitled to compensation for their losses. Juries should decide what noneconomic damages should be awarded.

The Subcommittee voted not to approve the proposed legislation.

Clarifying Statutes of Limitation Language for Malpractice Claims[22]

Greg Petesch, Code Commissioner, proposed legislation to clarify the intent of two MCA sections. The first was to correct a change in 27-2-205, MCA, that resulted from amendments in 1987. The word "plaintiff" should read "defendant", and the remainder of the section should be made gender-neutral. The second change proposed was to 27-6-702, MCA. The new language was drafted to reflect the minority opinion in the Montana Supreme Court case Eisenmenger v. Ethicon, Inc., 264 Mont. 393, 871 P.2d 1313, to toll the statute of limitations on malpractice actions only.

Gerald Neely, MMA, had no problem with revising 27-2-205, MCA, as proposed, but he testified that the original intent of the current language in 27-6-702, MCA, was reflected in the majority opinion in Eisenmenger so that the broader term "court action" would stop the clock from running against anyone else that might be associated with the claim, whether they were health care providers or not. Mr. Neely presented the Subcommittee with alternative language to amend 27-6-702, MCA, to reflect the minority opinion.

Russell Hill, MTLA, agreed with Mr. Neely and the MMA, and he also presented suggested language changes to the Subcommittee to reflect the minority opinion. Mr. Neely agreed with Mr. Hill's suggested language.

The Subcommittee approved the legislation proposed by Mr. Petesch as amended by Mr. Hill. (See Appendix A.)

INSURANCE REGULATION

Requiring a Medical Malpractice Insurer to Report Its Experience to the Insurance Services Office and Requiring a Medical Malpractice Insurer to Include a Comparison of Its Pricing With the Advisory Pricing of the Insurance Services Office When Filing Rates With the Commissioner of Insurance.[23]

Draft legislation was prepared at the request of Senator Klampe based on a suggestion by Randy Nordquist of the Office of the Commissioner of Insurance. The purpose of the legislation was to provide the Commissioner of Insurance with additional information with which to review the rates of medical malpractice insurers. A similar requirement for reviewing rates for hail insurance on crops is provided for in the Administrative Rules of Montana.

Jacqueline Lenmark, testifying on behalf of the American Insurance Association, opposed the proposed legislation saying that it raised a lot of questions on the part of insurance companies. The term "malpractice experience" may be open to litigation, and the language in the proposed legislation raises antitrust issues.

Roger McGlenn, Independent Insurance Agents Association of Montana, also testified in opposition to the proposed legislation.

The Subcommittee tabled the proposed legislation.

MONTANA MEDICAL LEGAL PANEL

Revising the Montana Medical Legal Panel Act[24]

Draft legislation was requested by Senator Klampe based on suggestions made by the MTLA. The proposal allows for summary disposition of claims and for transcripts of Montana Medical Legal Panel (Panel) proceedings, requires the Panel to articulate its reasons for a decision, and requires mandatory, nonbinding mediation for an affirmative Panel decision.

Russell Hill, MTLA, stated that the MTLA had no objection to striking any objectionable portions of the proposed legislation and adopting only those portions that are agreed upon.

Gerald Neely, MMA, testified that allowing summary disposition as proposed was ill-advised and could potentially lead to the destruction of the Panel. Requiring a transcript of hearings was also ill-advised according to Mr. Neely because the transcripts are not admissible as evidence, a transcript would formalize an informal process, and requiring transcripts could raise the costs. He further testified that requiring an explanation of the decision was an excellent suggestion, although in the case of a tie, the language was not clear as to final disposition. Finally, Mr. Neely supported mediation to encourage the settlement of claims.

With regard to summary disposition, Randy Dix, MTLA, testified that there are certain cases in which both sides agree that the Panel serves no useful purpose and only delays the process 4 to 6 months. With respect to requiring transcripts, the Panel serves less purpose if people offer unsworn testimony that has no meaning later during discovery.

After discussion of the proposed legislation, the Subcommittee agreed to recommend legislation implementing sections 3, 4, and 5. The MTLA and the

MMA agreed to work on the other portions of the proposed legislation. (See Appendix A.)

HEALTH CARE PROVIDERS

Limiting the Fee that a Health Care Provider May Charge for Providing Health Care Information Authorized by a Patient[25]

Testifying on proposed legislation requested by the MTLA, Russell Hill stated that the reason for the proposal is that the law now states that a claimant cannot be charged more than the actual cost of providing the health care information. However, many providers contract with companies for records management, and the companies charge exorbitant amounts for copying records.

Gerald Neely, MMA, testified that there have been some "horror stories" on the costs of medical records, but that the Montana Medical Legal Panel currently is the party that obtains records, at no direct cost to the claimants.

The Subcommittee tabled the proposed legislation.

Requiring Physicians to Carry Professional Liability Insurance[26]

Commenting on another proposal drafted at the request of the MTLA, Russell Hill stated that this legislation was proposed on the assumption that physicians need help with their malpractice premiums and that it was designed to help with the insurance market. He further stated that had he foreseen the agreements reached thus far, this proposed legislation probably would not have been on the agenda.

Jerry Loendorf, MMA, questioned the purpose of the proposed legislation and asked why licensed providers in addition to physicians were not required to

have insurance. Brian Zins, MMA, testified that he knew of no hospital in Montana that did not require liability insurance as a condition of staff privileges.

Jacqueline Lenmark, American Insurance Association, testified that the insurance industry is typically against mandatory coverage because it tends to drive up premiums and that enforcement of mandates is always a problem.

Roger McGlenn testified that the Independent Insurance Agents Association of Montana opposes mandatory coverage because such coverage has proven to be ineffective in many states.

Senator Doherty stated that he would be interested in a requirement that professionals, such as doctors and lawyers, post the fact that they carry professional liability insurance in their waiting rooms or otherwise notify patients or clients.

The Subcommittee tabled the proposed legislation.

OTHER ISSUES

In addition to the legislative proposals prepared by the Subcommittee staff, the Subcommittee reviewed four other issues for possible legislative consideration:

- prohibit a physician from referring a patient to a health care facility in which the physician has a financial interest;
- require insurance companies to require continuing education on how to avoid medical malpractice suits;
- increase penalties for violations by insurance companies of "file and use" rate regulations; and
- enact an experience rating law for medical malpractice insurance.

The Subcommittee briefly discussed each of these proposals, but chose to not propose any of them as legislation.

CONCLUSION

When the Joint Interim Subcommittee on Insurance Issues held its first meeting in September 1993, the Subcommittee was faced with a myriad of complex tort reform issues. The Subcommittee's initial task was to select those issues believed to be the most important and worthy of further study. As the Subcommittee worked through each of the issues, it soon became clear that medical malpractice was the major issue of concern for individual members of the Subcommittee as well as for various interest groups.

The Subcommittee's study of medical malpractice began with the question: "Is there a medical malpractice crisis in Montana that warrants the passage of tort reform measures?". The Subcommittee analyzed the information gathered by its staff on medical malpractice insurance rates, claims and lawsuits filed, and claims and lawsuits settled. The Subcommittee looked at medical malpractice statutes and medical malpractice insurance premiums in neighboring states. The Subcommittee also took testimony from proponents and opponents of specific tort reform measures and reviewed eight legislative proposals requested by various interest groups and individual Subcommittee members.

After 12 months of study, the Subcommittee concluded that the evidence presented to the Subcommittee did not support the contention that there was a medical malpractice crisis in Montana that warranted the passage of specific tort reform measures. Further, no evidence was presented that supported the contention that the passage of tort reform measures would result in health care cost savings, either to health care providers or consumers. Therefore, the recommendations of the Subcommittee should not be interpreted as the Subcommittee's answer to a perceived medical malpractice crisis. Rather, the recommendations reflect an attempt to fine-tune a process that, in the Subcommittee's view, is currently working.

The Subcommittee was also apprised of the limitations on the available data on medical malpractice in Montana. Therefore, the conclusion regarding the

absence of a medical malpractice crisis in Montana must be viewed in light of the data limitations. If the agencies responsible for collecting and maintaining the information correct the problems identified by the Subcommittee, the issue of medical malpractice may need to be revisited in the future.

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ENDNOTES

19. Joint Interim Subcommittee on Insurance Issues, Minutes, August 26, 1994, Montana Legislative Council, Exhibit #2, LC000B.

20. Ibid., Exhibit #3, LC000A.

21. Ibid., Exhibit #4, LCINS2.SBF.

22. Ibid., Exhibit #5, LCins1.sbf.

23. Ibid., Exhibit #7, LC000D.

24. Ibid., Exhibit #8, LCins4.sbf.

25. Ibid., Exhibit #10, LC000G.

26. Ibid., Exhibit #11, LC000F.

APPENDIX A

_____ BILL NO. _____

INTRODUCED BY _____

BY REQUEST OF THE JOINT INTERIM SUBCOMMITTEE ON INSURANCE ISSUES

A BILL FOR AN ACT ENTITLED: "AN ACT CLARIFYING THE TOLLING OF APPLICABLE STATUTES OF LIMITATIONS RELATED TO MEDICAL MALPRACTICE CLAIMS; AND AMENDING SECTIONS 27-2-205 AND 27-6-702, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 27-2-205, MCA, is amended to read:

"**27-2-205. Actions for medical malpractice.** (1) Action in tort or contract for injury or death against a physician or surgeon, dentist, registered nurse, nursing home or hospital administrator, dispensing optician, optometrist, licensed physical therapist, podiatrist, psychologist, osteopath, chiropractor, clinical laboratory bioanalyst, clinical laboratory technologist, pharmacist, veterinarian, a licensed hospital or long-term care facility, or licensed medical professional corporation, based upon alleged professional negligence or for rendering professional services without consent or for an act, error, or omission, ~~shall~~ must, except as provided in subsection (2), be commenced within 3 years after the date of injury or within 3 years after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs last, but in no case may ~~such~~ an action be commenced after 5 years from the date of injury. However, this time limitation ~~shall be~~ is tolled for any period during which there has been a failure to disclose any act, error, or omission upon which ~~such~~ an action is based and ~~which~~ that is known to the ~~plaintiff~~ defendant or through the use of reasonable diligence subsequent to ~~said~~ the act, error, or omission would have been known to ~~him~~ the defendant.

(2) Notwithstanding the provisions of 27-2-401, in an action for death or injury of a minor who was under the age of 4 on the date of ~~his~~ the minor's injury, the period of limitations in subsection (1) begins to run when the minor reaches ~~his~~ the minor's eighth birthday or dies, whichever occurs first, and the time for commencement of the action is tolled during any period during which the minor does not reside with a parent or guardian."

Section 2. Section 27-6-702, MCA, is amended to read:

"**27-6-702. Tolling of statute of limitations.** The running of the applicable limitation period ~~in~~ related to a malpractice claim is tolled upon receipt by the director of the application for review as to all health care providers named in the application as parties to the panel proceeding and as to all other persons or entities named in the application as necessary or proper parties for any court action ~~which~~ that might subsequently arise out of the same factual circumstances set forth in the application. The running of the applicable limitation period ~~in a malpractice claim~~ does not begin again until 30 days after either an order of dismissal, with or without prejudice against refiling, is issued from the panel chairman, or from the director upon the consent of the parties to the claim, or after the panel's final decision, whichever occurs first, is entered in the permanent files of the panel and a copy is served upon the complainant or ~~his~~ the complainant's attorney if ~~he is~~ represented by counsel, by certified mail."

-END-

_____ BILL NO. _____

INTRODUCED BY _____

BY REQUEST OF THE JOINT INTERIM SUBCOMMITTEE ON INSURANCE ISSUES

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING THE MONTANA MEDICAL LEGAL PANEL ACT; REQUIRING THAT, UPON REQUEST, THE PANEL ARTICULATE THE REASONING AND BASIS FOR A DECISION; REQUIRING MANDATORY, NONBINDING MEDIATION FOR AN AFFIRMATIVE PANEL DECISION; AND AMENDING SECTIONS 27-6-604, 27-6-606, AND 27-6-704, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 27-6-604, MCA, is amended to read:

"**27-6-604. Form and content of decision.** The decision ~~shall~~ must in every case be signed for the panel by the chairman ~~and shall~~, must contain only the conclusions reached by a majority of its members, and ~~shall~~ must list the number of members, if any, dissenting ~~therefrom~~ from the opinion. ~~The~~ Upon request of any party, the majority ~~may~~ shall briefly explain the reasoning and ~~the~~ basis for ~~their~~ the decision~~,~~ and the dissenters ~~may likewise~~ shall explain the ~~reason~~ reasoning and basis for disagreement."

Section 2. Section 27-6-606, MCA, is amended to read:

"**27-6-606. Decision not binding -- settlement agreements -- nonbinding mediation.** (1) The panel's decision is without administrative or judicial authority and is not binding upon any party.

(2) The panel may recommend an award, approve settlement agreements, and discuss the ~~same~~ settlement agreements, all in a manner ~~not inconsistent~~ consistent with this part~~, and all such~~. All approved settlement agreements are binding on the parties.

(3) If the panel decides both questions required by 27-6-602 in the affirmative, the court in which the complaint is filed shall require the parties to participate in court-supervised, nonbinding mediation prior to proceeding."

Section 3. Section 27-6-704, MCA, is amended to read:

"**27-6-704. Panel proceedings and decision privileged from disclosure in court actions.** (1) ~~No~~ A

panel member may not be called to testify in ~~any~~ a proceeding concerning the deliberations, discussions, decisions, and internal proceedings of the panel.

(2) The decision and the reasoning and basis for the decision of the ~~medical review~~ panel ~~is~~ are not admissible as evidence in ~~any~~ an action subsequently brought in ~~any~~ a court of law."

-END-

APPENDIX B

**** Bill No. ***

Introduced By **********

By Request of [Montana Medical Association]

A Bill for an Act entitled: "An Act limiting medical malpractice noneconomic damages to $500,000 for a single incident of malpractice; and providing an applicability date."

Be it enacted by the Legislature of the State of Montana:

NEW SECTION. **Section 1. Medical malpractice noneconomic damages limitation.** (1) In a malpractice claim action or actions against one or more health care providers based on a single incident of malpractice, the combined awards for past and future damages for noneconomic loss may not exceed $500,000, whether for one or more claimants in the same or separate proceedings; whether based on the same act or a series of acts that allegedly caused the injury, injuries, death, or deaths that the action or actions are based on; and whether the act or series of acts were by one or more health care providers. A claimant has the burden of proving separate injuries, each arising from a different act or series of acts. An award or combination of awards in excess of $500,000 must be reduced to $500,000, after which the court shall make other reductions required by law. If a combination of awards for past and future noneconomic loss is reduced to $500,000, a claimant's share of the $500,000 must be the same percentage as the claimant's share of the combined awards before reduction. For

each claimant, further reductions must be made in the following order:

(a) first, reductions under 27-1-702;

(b) second, reductions under 27-1-703; and

(c) third, setoffs and credits to which a defendant is entitled.

(2) An award of future damages for noneconomic loss may not be discounted to present value.

(3) The $500,000 limit in subsection (1) may not be disclosed to a jury.

(4) As used in this section the following definitions apply:

(a) "Claimant" includes but is not limited to a person suffering bodily injury; a person claiming as a result of bodily injury to or the death of another; a person claiming on behalf of someone who suffered bodily injury or death; the representative of the estate of a deceased person; or a person bringing a wrongful death action.

(b) "Health care provider" means a physician, licensed under Title 37, chapter 3; a dentist, licensed under Title 37, chapter 4; a nurse licensed under Title 37, chapter 8; or health care facility, as defined in 27-6-103.

(c) "Malpractice claim" has the meaning as defined in 27-6-103.

(d) "Noneconomic loss" means subjective, nonmonetary loss, including but not limited to physical and mental pain or suffering; emotional distress; inconvenience; fright; grief;

sorrow; loss of society, companionship, and consortium (other than household services); injury to reputation; and humiliation.

NEW SECTION. **Section 2. Applicability.** [This act] applies to causes of action arising on or after October 1, 1995.

-END-

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LC000A

**** Bill No. ***

Introduced By **********

By Request of [Montana Medical Association]

A Bill for an Act entitled: "An Act mandating the periodic payment of future damages of $100,000 or more in an action for personal injury, property damage, and or wrongful death; amending section 25-9-403, MCA; and providing an applicability date."

Be it enacted by the Legislature of the State of Montana:

Section 1. Section 25-9-403, MCA, is amended to read:

"**25-9-403. Request for periodic payment of future damages.** (1) A party to an action for personal injury, property damage, or wrongful death in which $100,000 or more of future damages is awarded may, prior to the entry of judgment, request the court to enter a judgment ordering future damages to be paid in whole or in part by periodic payments rather than by a lump-sum payment. Upon ~~such~~ a request, the court ~~may~~ shall enter an order for periodic payment of future damages ~~if~~ unless the court finds that ~~such~~ periodic payment is not in the best interests of the claimant. The total dollar amount of the ordered periodic payments must equal the total dollar amount of the future damages without a reduction to present value.

(2) A court ordering the payment of future damages by periodic payments shall make specific findings as to the dollar

amount of periodic payments needed to compensate the judgment creditor for future damages ~~and as to whether an order for periodic payment of future damages is in the best interests of the claimant~~.

(3) The judgment order must specify the recipient or recipients of periodic payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments ~~shall~~ must be made.

(4) A court ordering periodic payment of future damages shall order that the payments be made, during the life of the judgment creditor or during the continuance of the compensable injury or disability of the judgment creditor, through the purchase of an inflation-indexed annuity approved by the court. The annuity must be in the form of an inflation-indexed annuity contract purchased from a qualified insurer that, in the most recent edition of A.M. Best, has an "A" (excellent) or higher rating and is in a class 7 or higher classification. The annuity also serves as any required supersedeas bond. Upon purchase of a court-approved annuity, the court may order that the judgment is satisfied and that the judgment debtor is discharged. If the judgment creditor dies before all periodic payments have been made, the remaining payments become the property of his estate. "

{*Internal References to 25-9-403: None.*}

NEW SECTION. **Section 2. {standard} Saving clause.** [This act] does not affect rights and duties that matured, penalties

that were incurred, or proceedings that were begun before [the effective date of this act].

NEW SECTION. **Section 3. {Standard} Applicability.** [This act] applies to causes of action arising on or after October 1, 1995.

-END-

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LC000B

**** Bill No. ***

Introduced By **********

By Request of [Montana Medical Association and The Doctors' Company]

A Bill for an Act entitled: "An Act limiting medical malpractice contingency attorney fees; amending section 25-10-301 and 72-3-633, MCA; and providing an applicability date."

Be it enacted by the Legislature of the State of Montana:

NEW SECTION. **Section 1. Medical malpractice contingency attorney fees -- limits.** (1) An attorney may not contract for, charge, collect, or receive a contingency fee for representing a claimant in a malpractice claim against a health care provider, in excess of:

(a) 40% of the first $50,000 recovered;

(b) 33 1/3% of the next $50,000 recovered;

(c) 25% of the next $500,000 recovered; and

(d) 15% of any amount above $600,000 recovered.

(2) The limits in subsection (1) apply whether the recovery is by settlement, arbitration, judgement, appeal from a judgement, or otherwise. An attorney compensated under 72-3-633 in a malpractice claim against a health care provider is subject to the limits of subsection (1), but the court may approve a fee less than the maximum permitted by subsection (1).

(3) The percentage and dollar amount limits in subsection (1) apply to the combined recoveries in a malpractice claim in which one or more attorneys represent one or more claimants for one or more injuries or deaths allegedly arising from the same act or series of acts.

(4) As used in this section, the following definitions apply:

(a) "Health care provider" means a physician, licensed under Title 37, chapter 3; a dentist, licensed under Title 37, chapter 4; a nurse, licensed under Title 37, chapter 8; or a health care facility, as defined in 27-6-103.

(b) "Malpractice claim" has the same meaning as in 27-6-103.

(c) "Recovery" means the net sum received after deductions for disbursements or costs incurred in connection with the prosecution or settlement of a claim. Costs of medical care, amounts deducted as collateral sources under 27-1-308, and an attorney's office overhead costs are not deductible disbursements or costs.

Section 2. Section 25-10-301, MCA, is amended to read:

"**25-10-301. Determining compensation of attorneys.** ~~The~~ (1) Except as provided in [section 1] and subsection (2), the measure and mode of compensation of attorneys and counselors at law is left to agreement, express or implied, of the parties~~, except that in~~.

(2) In probate proceedings the court may fix and allow the

compensation of attorneys representing administrators, executors, guardians, trustees, and agents appointed by the court. ~~But parties~~

(3) Parties to actions or proceedings are entitled to costs and disbursements as provided by law."

{Internal References to 25-10-301: None.}

Section 3. Section 72-3-633, MCA, is amended to read:

"**72-3-633. Compensation of attorney.** (1) ~~If~~ Except as provided in [section 1} with respect to a malpractice claim, if the services of an attorney are engaged by the personal representative, the compensation of ~~such~~ the attorney ~~shall~~ may not exceed 1 1/2 times the compensation allowable to the personal representative.

(2) If the services of an attorney are engaged by the personal representative to assist in the termination of joint tenancies, the compensation allowed the attorney ~~shall~~ may not exceed 3% of the interest passing.

(3) If the services of an attorney are engaged in connection with the termination of a life estate, the compensation allowed the attorney ~~shall~~ may not exceed 3% of the value of the life estate if it is terminated in connection with a probate or joint tenancy termination. If a life estate is terminated separately, the attorney's compensation ~~shall~~ may not exceed 3%, except that it shall not be less than $100.

(4) If the services of more than one attorney are engaged, only one compensation ~~shall~~ must be allowed.

(5) In cases where further compensation may be allowed to an attorney, the same must be fixed and determined by the court upon good cause shown after notice and hearing of an application therefor."

{Internal References to 72-3-633:
X 72-3-104 X 72-15-301}*

NEW SECTION. **Section 4. {standard} Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 25, chapter 10, part 3, and the provisions of Title 25, chapter 10, part 3, apply to [section 1].

NEW SECTION. **Section 5. {standard} Saving clause.** [This act] does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before [the effective date of this act].

NEW SECTION. **Section 6. {Standard} Applicability.** [This act] applies to causes of action arising on or after October 1, 1995.

-END-

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LC000D

**** Bill No. ***

Introduced By **********

By Request of [Sen. Klampe]

A Bill for an Act entitled: "An Act requiring a medical malpractice insurer to report its experience to the insurance services office; requiring a medical malpractice insurer to include a comparison of its rates with the advisory rates of the insurance services office when filing rates with the insurance commissioner; and amending section 33-16-203, MCA."

Be it enacted by the Legislature of the State of Montana:

NEW SECTION. **Section 1. Reporting required.** Each insurer writing medical malpractice insurance in this state shall annually report its medical malpractice experience to the insurance services office.

Section 2. Section 33-16-203, MCA, is amended to read:

"**33-16-203. Rates filed.** (1) Every insurer, rating organization, or advisory organization shall file with the commissioner all rates intended for use within this state, together with supporting data sufficient to substantiate such filing. The filing required by this subsection may be made by rating organizations on behalf of their members and subscribers; but this provision does not prohibit a member or subscriber from

filing any such rates on its own behalf. Any deviations from a rating organization's rates by a member or subscriber must be filed with the commissioner and must be accompanied by supporting data.

(2) In accordance with 33-16-222, rates filed must provide for a premium reduction to qualified insured operators 55 years of age or older.

(3) When a medical malpractice insurer files its rates with the commissioner, the filing must include a comparison of the insurer's rates with the advisory rates of the insurance services office in a format that allows a direct comparison between the rates."

{*Internal References to 33-16-203:*
X 33-16-402}

NEW SECTION. **Section 3. {standard} Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 33, chapter 16, part 2, and the provisions of Title 33, chapter 16, part 2, apply to [section 1].

-END-

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LC000F

**** Bill No. ***

Introduced By **********

By Request of [Montana Trial Lawyers' Association]

A Bill for an Act entitled: "An Act requiring physicians to carry professional liability insurance; amending sections 37-3-305 and 37-3-307, MCA; and providing an applicability date."

Be it enacted by the Legislature of the State of Montana:

Section 1. Section 37-3-305, MCA, is amended to read:

"**37-3-305. Qualifications for licensure.** (1) A person may not be granted a physician's license to practice medicine in this state unless the person:

(a) is of good moral character, as determined by the board;

(b) is a graduate of an approved medical school as defined in 37-3-102;

(c) has completed an approved internship of at least 1 year or, in the opinion of the board, has had experience or training that is at least the equivalent of 1 year internship;

(d) has had a completed application file reviewed by a board member and, at the discretion of the board member, has made a personal appearance before the board; ~~and~~

(e) is able to communicate, in the opinion of the board, in the English language; and

(f) provides proof of professional liability insurance

coverage of at least $1 million.

(2) The board may authorize the department to issue the license subject to terms of probation or other conditions or limitations set by the board or may refuse a license if the applicant has committed unprofessional conduct or is otherwise unqualified.

(3) A person may not be granted a temporary license to practice medicine in this state unless the person:

(a) is of good moral character, as determined by the board;

(b) is a graduate of an approved medical school as defined in 37-3-102;

(c) has completed an approved internship of at least 1 year or, in the opinion of the board, has had experience or training that is at least the equivalent of 1 year internship;

(d) has made a personal appearance before at least one member of the board; ~~and~~

(e) is able, in the opinion of the board, to communicate in the English language; and

(f) provides proof of professional liability insurance coverage of at least $1 million."

{Internal References to 37-3-305:
X 37-3-311}

Section 2. Section 37-3-307, MCA, is amended to read:

"**37-3-307. Qualifications for licensure -- temporary certificate.** (1) The board may authorize the department to issue to an applicant a temporary certificate to practice medicine on

the basis of:

(a) passing an examination given and graded by the department, subject to 37-1-101;

(b) certification of record or other certificate of examination issued to or for the applicant by the national board of medical examiners or successors, by the federation licensing examination committee or successors, or by the medical council of Canada or successors if the applicant is a graduate of a Canadian medical school which has been approved by the medical council of Canada or successors, certifying that the applicant has passed an examination given by the board; or

(c) a valid, unsuspended, and unrevoked license or certificate issued to the applicant on the basis of an examination by an examining board under the laws of another state or territory of the United States or of the District of Columbia or of a foreign country whose licensing standards at the time the license or certificate was issued were essentially equivalent, in the judgment of the board, to those of this state at the time for granting a license to practice medicine; ~~and~~

(d) being a graduate of an approved medical school who has completed 1 year of internship or its equivalent and being of good moral character and good conduct; and

(e) providing proof of professional liability insurance coverage of at least $1 million.

(2) The board may require that graduates of foreign medical schools pass the examination given by the education council for foreign medical graduates or successors.

(3) A temporary license may be issued to a physician employed by a public institution who is practicing under the direction of a licensed physician. The board may authorize the department to issue a temporary license subject to terms of probation or other conditions or limitations set by the board or may refuse a temporary license to a person if he has committed unprofessional conduct. The issuance of a temporary certificate imposes no future obligation or duty on the part of the board to grant full licensure or to renew or extend the temporary license. The board may, in the case of an applicant for a temporary certificate, require a written, oral, or practical examination of the applicant."

{*Internal References to 37-3-307: None.*}

NEW SECTION. **Section 3. {Standard} Applicability.** [This act] applies to all physicians applying for licensure and to all physicians renewing their licenses on or after October 1, 1995.

-END-

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LC000G

**** Bill No. ***

Introduced By **********

By Request of [Montana Trial Lawyers' Association]

A Bill for an Act entitled: "An Act limiting the fee a health care provider may charge for providing health care information authorized by a patient; and amending section 50-16-526, MCA."

Be it enacted by the Legislature of the State of Montana:

Section 1. Section 50-16-526, MCA, is amended to read:

"**50-16-526. Patient authorization to health care provider for disclosure.** (1) A patient may authorize a health care provider to disclose the patient's health care information. A health care provider shall honor an authorization and, if requested, provide a copy of the recorded health care information unless the health care provider denies the patient access to health care information under 50-16-542.

(2) A health care provider may charge a reasonable fee, not to exceed ~~his actual cost~~ 25 cents per page for providing the health care information, and is not required to honor an authorization until the fee is paid.

(3) To be valid, a disclosure authorization to a health care provider must:

(a) be in writing, dated, and signed by the patient;

(b) identify the nature of the information to be disclosed;

and

(c) identify the person to whom the information is to be disclosed.

(4) Except as provided by this part, the signing of an authorization by a patient is not a waiver of any rights a patient has under other statutes, the Montana Rules of Evidence, or common law."

{*Internal References to 50-16-526:*
X 50-16-513 X 50-16-551}

-END-

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